

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age, / is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12086 P

CERTIFICATE OF DEATH

Reg. Dist. No. 7C

1. PLACE OF DEATH:
Carroll
County

City or town... Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? less than 24 hours

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? less than 24 hours

3. (a) FULL NAME
Arthur Adams

WILLIAM ARTHUR ADAMS

4. Sex
Male

5. Color or race
White

6. (a) Single, married, widowed, or divorced
Married

8. (b) Name of husband or wife
Anna Adams

7. Birth date of
deceased (mo., day, yr.)
Not known

6. (c) If alive, give age..... years

June 30, 1873

8. AGE: Years
72

Months
5

Days
18

If less than one day
hrs. min.

9. Birthplace
Bedford County, Pennsylvania

(Town, county, and state)

10. Usual occupation
Machinist

11. Industry or business

12. Name
Not known

13. Birthplace
Not known

14. Maiden name
Anna Kensinger

15. Birthplace
Not known

16. Informant
Records of Springfield State
Hospital, Sykesville, Md.

Address

17. Burial made
(Burial, cremation, or removal. Which?)

Date thereof 12-15-45

(month) (day), (year)

Cemetery or crematory
Oaklawn Cemetery

Location

Eastern Avenue

18. Funeral director
Wendell E. Humphreys

Address

6067 Harford Rd

19. (Date rec'd by registrar)

12/14/45

Abbie Heluck

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland
County Baltimore

City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)

Street No. 27 Seabright Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH
December 11 1945 at 11:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
December 11, 1945, to December 11, 1945,
and that I last saw him alive on December 11, 1945.

Immediate cause of death

Bronchitis-pneumonia

Due to

Due to

Other conditions Psychotic Organic Brain
Disease

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Arnold H. Eichert M.D.

M. D. or other

Address 11000 Sykesville Rd, Md. Date signed 12-12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 40

12087

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH: Carroll
 County.....
 City or town..... rural near Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 years
 Hospital, institution, or street address where death occurred: Springfield State Hospital (employee)
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Carroll
 City or town..... rural near Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Springfield State Hospital
 (If rural, give LOCATION)

3. (a) FULL NAME Harry Fessler Baer
 4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Ruth Elizabeth Dallmus
 7. Birth date of deceased (mo., day, yr.) December 15, 1871 6. (c) If alive, give age 54 years
 8. AGE: Years Months Days If less than one day
 74 -- 3 hrs. min.
 9. Birthplace Tannery, Carroll County, Md. (Town, county, and state)
 10. Usual occupation Physician, mental diseases
 11. Industry or business State Mental Hospital
 12. Name of father James Shellman Baer
 13. Birthplace Baltimore City, Maryland
 14. Maiden name Susan Kimball Fessler
 15. Birthplace Frederick, Maryland
 16. Informant Mrs. Ruth Baer (widow)
 Address Sykesville, Maryland

17. Burial Date thereof Dec. 19, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Springfield Cemetery
 Location Sykesville, Md.
 18. Funeral director C. Harry Baer
 Address Sykesville, Md.
 19. Date rec'd by registrar Dec. 19 1945 C. Harry Baer
 (Date rec'd by registrar) Registrar

2. (a) If veteran, name war.....
 3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 1945, at 5:15 p.m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15, 1943, to Dec. 18, 1945, and that I last saw him alive on December 18, 1945.

Immediate cause of death Coronary occlusion
 DURATION 18 days

Due to Arteriosclerosis, more than 2 yrs.

Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

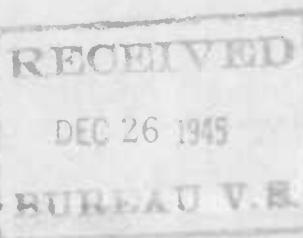
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?
 Robert Bertrand May, M.D.

23. SIGNATURE Robert Bertrand May, M.D.
 Springfield State Hospital M.D. for other
 Sykesville, Maryland Date signed 12-18-45
 Address.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 130

12688

P

CERTIFICATE OF DEATH

Reg. Distr. No.

74

1. PLACE OF DEATH:

County..... Carroll

City or town..... Bryn Mawr

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 3 yrs. 7 mos.

Hospital, Institution, or street address where death occurred:..... Springfield Rest. & Hospital

How long in hospital or institution?..... 3 yrs 7 mos.

3. (a) FULL NAME

William H. Baer.

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Widowed

6. (b) Name of husband or wife..... Unknown

7. Birth date of deceased (mo., day, yr.)..... July 6, 1890 8. (c) If alive, give age..... years

8. AGE: Years..... 55 Months..... 5 Days..... 90 If less than one day..... hrs..... min.....

9. Birthplace..... Baltimore Md. (Town, county, and state)

10. Usual occupation..... Painter

11. Industry or business..... Charles Baer

12. Name..... Charles Baer

13. Birthplace..... Baltimore Md.

14. Maiden name..... Ruth Lynde

15. Birthplace..... Baltimore Md.

16. Informant..... Borgelae Records

Address..... Bryn Mawr

17. Burial, cremation, or removal. Which?..... Burial

Date thereof..... 12/28/45 (month) (day) (year)

Cemetery or crematory..... Oak Lawn Cemetery

Location..... 7225 Eastern Ave.

18. Funeral director..... John J. Howard Jr.

Address..... 100-03 Hollins Street

19. Date rec'd by registrar..... 12/25/45 1945

Registrar..... A. W. Kedrich

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County.....

City or town..... Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 200 Bryn Mawr

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec. 25 1945 at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 23 1945 to Dec. 25 1945

and that I last saw him alive on Dec. 25, 1945.

Immediate cause of death.....

Chronic myocarditis

Chronic interstitial nephritis

Due to..... Generalized arteritis arteritis

DURATION

6 mos.

6 mos.

Due to.....

Other conditions..... Schizophreria, Paranoia

5 years

(Include pregnancy within 3 months of death)

Major findings of operations..... None

Date of op.

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE..... Kenneth G. Jones

M. D. or other

Address..... Bryn Mawr

Date signed/12/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19

12089

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County... Carroll

City or town... Gamber

(If outside city or town limits, write RURAL and give nearest town)

life

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Earl LeRoy Barnes

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

divorced

8. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

May 2, 1901

8. AGE:

Years

Months

Days

It less than one day

44

7

18

hrs.

mies.

9. Birthplace Carroll County, Maryland
(Town, county, and state)

10. Usual occupation.

labor

11. Industry or business

12. Name R. Hanson Barnes

13. Birthplace Maryland

14. Maiden name Emma A. Yingling

15. Birthplace Maryland

16. Informant Mrs. Charles L. Caltrider

Address Gamber, Md.

17. burial

(Burial, cremation, or removal. Which?)

Date thereof 12/22/45

(month) (day) (year)

Cemetery or crematory Calvary Cemetery

Location Gamber, Md.

18. Funeral director J. Francis Reese

Address Westminster, Md.

19. (Date rec'd by registrar)

19. 45

J. C. Glazebrook

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant give residence of mother)

State Maryland County Carroll

City or town Gamber

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war none

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1945 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 20 1945 to December 20 1945

and that I last saw him alive on December 20 1945.

Immediate cause of death

Freeze Alabesee -

Due to Exposure to freezing Weather

12 hours

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. C. Glazebrook, M.D.

D. or other

Address Westminster, Md. Acting Deputy M.D. Date signed 1/1/46

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BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

12690

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
 County... Carroll
 City or town... Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 yrs. 5 mos. 13 days
 Hospital, institution, or street address where death occurred:
 Springfield State Hospital
 How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... Maryland County... Carroll
 City or town... Sykesville, rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war. _____

3. (a) FULL NAME

Ernest Norris Bennett

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife. _____

7. Birth date of deceased (mo., day, yr.) July 3, 1910
 (If alive, give age) years

8. AGE:	Years	Months	Days	If less than one day
	35	5	13	hrs. _____ min. _____

9. Birthplace... Carroll Co. Md.
 (Town, county, and state)

10. Usual occupation... Farmer

11. Industry or business

FATHER
 12. Name... George A. Bennett
 13. Birthplace... Maryland

MOTHER
 14. Maiden name... Hattie Leatherwood
 15. Birthplace... Maryland

16. Informant... Records of Springfield State
 Hospital, Sykesville, Md.

Burial
 (Burial, cremation, or removal. Which?) Date thereof... Dec. 17, 1945
 (month) (day) (year)

Cemetery or crematory... Oakland Methodist Cemetery
 Location... 701 Oakland Mills, Carroll Co., Md.

18. Funeral director... C. Harry Eichart
 Address... Sykesville, Md.

19. Dec. 15 1945 C. Harry Eichart
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH... December 14 1945 at 7:50A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
 (month) Dec. 9 1945 to Dec. 14 1945
 and that I last saw him alive on December 14 1945

Immediate cause of death

Bronchopneumonia (terminal)

Due to
 Cerebral edema of right elbow cont.

Due to

Other conditions Schizophrenia, Catatonic type

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arnold H. Eichart, M.D.

M. D. or other

Address... 1100 Sykesville, Md. Date signed 12-14-45

RECEIVED IN THE LIBRARY OF CONGRESS

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DEC 19 1945

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12691

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:

County.....

City or town.....

Carroll.

Manchester, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 71 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Charles Granville Bish

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married

6. (b) Name of husband or wife.....

Irene Rebecca Farmer

7. Birth date of

deceased (mo., day, yr.)

Nov 9 1874

8. AGE:

Years

Months

Days

If less than one day

71

1

20

. hrs.

. min.

9. Birthplace.....

Carroll County, Md.

(Town, county, and state)

10. Usual occupation.....

Retired Farmer 6 years.

11. Industry or business

12. Name.....

Wentworth Bish

13. Birthplace.....

Carroll County, Md.

14. Maiden name.....

Eliza Wrenzy

15. Birthplace.....

Carroll County, Md.

16. Informant.....

Mrs. Irene R. Bish

Address

Manchester, Md. Rd #1

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... Jan 2 1946

Cemetery or crematory.....

St. Bartholomew's Church

Location.....

Hanover Pa. Rd York County

18. Funeral director.....

W. A. Fleaser

Address

Hanover Pa.

19. Date rec'd by registrar

Dec 30 1945

M.D. W. F. L. Deemer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County.....

Carroll

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Manchester, Md. Rd #1

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 29 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10. 10.

19.

and that I last saw h..... alive on

19.

Immediate cause of death.....

Fracture cervical vertebrae

Due to..... Automobile accident

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations..... None

Date of op.

Autopsy results.....

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur.....

Manchester

Carroll

Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Route 30

Means of injury..... Automobile accident

at work?

23. SIGNATURE.....

T. Deemer, Deputy Medical Examiner

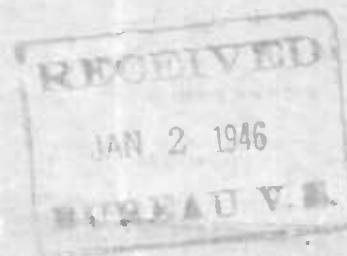
M. D. or other

Address.....

Westminister

Md

Date signed 12-29-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BD*

CERTIFICATE OF DEATH

Reg. Distr. No. 74

1. PLACE OF DEATH:
County Carroll

City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years, 5 months, 11 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1
(If rural, give LOCATION)

2.(a) If veteran, name war? ✓

3. (a) FULL NAME

DANIEL LEWIS BISHOP

4. Sex <u>male</u>	5. Color or race <u>col.</u>	6.(a) Single, married, widowed, or divorced <u>single</u>
--------------------	------------------------------	---

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) January 15, 1927 6.(c) If alive, give age..... years

8. AGE: Years <u>18</u>	Months <u>10</u>	Days <u>24</u>	It less than one day <u>hrs. 00</u>	min. 00
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9. Birthplace Snow Hill, Md.
(Town, county, and state)

10. Usual occupation Scholar

11. Industry or business

FATHER 12. Name Daniel Bishop
13. Birthplace Unknown

MOTHER 14. Maiden name Ella Bishop
15. Birthplace Unknown

16. Informant Reuben Hoffman, M.D.
Address Henryton, Maryland

17. Burial Burial Date thereof 12-14-45
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Snow Hill

Location Snow Hill, Md.

18. Funeral director Neorne & al-ens

Address Snow Hill, Md.

19. Dec. 9, 1945 Albert A. Swanson
(Date rec'd by registrar) Deputy Local Registrar

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9, 1945 at 6:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28, 1943 to Dec. 9, 1945 and that I last saw h. im alive on Dec. 9, 1945

Immediate cause of death Pulmonary Tuberculosis DURATION Feb. 1943

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

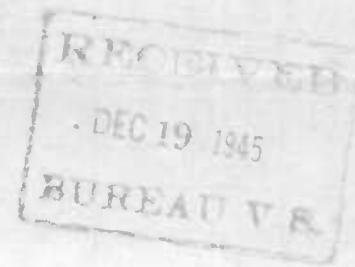
Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Address Henryton, Md. Date signed 12-9-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County... Carroll Co.

City or town... Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years approx.

Hospital, Institution, or street address where death occurred:

77 W. Green St.

How long in hospital or institution?.....

3. (a) FULL NAME

Carrie Matilda Bifler

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

f.

W.

widow

B. (b) Name of husband or wife...

George A. Bifler

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age years

Jan 4, 1860

8. AGE:

Years 85

Months 11

Days 18

If less than one day hrs. min.

9. Birthplace

Warfieldburg Carroll Co. Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

MOTHER FATHER

Levi Barnes

MOTHER

Carroll Co. Md.

FATHER

Matilda?

MOTHER

Carroll Co. Md.

16. Informant

Mr. Paul S. Bifler

Address

77 W. Green St. Westminster Md.

17. (Burial, cremation, or removal. Which?)

Burial Date thereof 12/24/45

(month) (day) (year)

Cemetery or crematory

Westminster Cemetery

Location

Westminster Maryland

18. Funeral director

J. S. Myers

Address

Westminster Md.

19. (Date rec'd by registrar)

12/23/45

(Date signed)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Carroll County... Carroll

City or town... Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 77 W. Green St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22, 1945, at 11:20 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

April 10, 1945, to Dec 22, 1945,

and that I last saw her alive on or about Dec 20, 1945.

Immediate cause of death... Organic Heart Disease

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

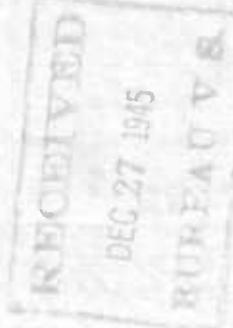
Means of injury..... Injured at work?

23. SIGNATURE

John J. Stegert M. D. or other

Address... Westminster, Md. Date signed Dec 22, 1945

LIBRARY OF THE STATE OF NEW YORK



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly. This correct age is especially important.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

12/93

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos. 9 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 4 mos. 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. Unknown
(If rural, give LOCATION)

3. (a) FULL NAME
Julia Bochniak
4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced
Married
6. (b) Name of husband or wife Andrew Bochniak
7. Birth date of deceased (mo., day, yr.) Nov. 17, 1919
8. (c) If alive, give age years
8. AGE: Years Months Days If less than one day
26 0 17 hrs. min.
9. Birthplace New Jersey
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
12. Name FATHER John Murowski
13. Birthplace Poland
14. Maiden name MOTHER Mary Sasinowski
15. Birthplace Poland
16. Informant Records of Springfield State Hospital, Sykesville, Md.
Address
17. Burial (Burial, cremation, or removal, which) Date thereof (month) (day) (year)
Cemetery or crematory St. Stanislaus
Location Battin
18. Funeral director Fred J. Ozagurski
Address 1900 Eastern Ave.
19. (Date rec'd by registrar) 12/6 19 X5 A. W. Bedard
(Date rec'd by registrar) D.M.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 19 45 at 9:45 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 25 19 45 to Dec. 4 19 45
and that I last saw her alive on Dec. 4 19 45

Immediate cause of death Chronic Lebrosis pulmonaria
Tuberculosis, far advanced
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings or operations
Date of op.

Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ellis L. Margolin, M.D.
M. D. or other
Address Sykesville, Md. Date signed Dec. 5 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 91

CERTIFICATE OF DEATH

12/95

Reg. Dist. No. 81

1. PLACE OF DEATH: Carroll
County

City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Emory Scott Boone

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widowed

8. (b) Name of husband or wife Alice Boone

7. Birth date of deceased (mo., day, yr.) September 19 1865
6. (c) If alive, give age years

8. AGE: Years	Months	Days	If less than one day
80	3	11 hrs. min.

9. Birthplace Frederick County Maryland
(Town, county, and state)

10. Usual occupation Barber

11. Industry or business Retired

12. Name Scott Boone

13. Birthplace Maryland

14. Maiden name Lydia -----

15. Birthplace Not Known

16. Informant Kernie R Boone

Address 1225 W. King St York Penna

17. Burial Beaver Dam Cemetery
(Burial, cremation, or removal. Which?) Date thereof Jan 2 1945
(month) (day) (year)

Cemetery or crematory

Location near Union Bridge Maryland

18. Funeral director D.D. Hartzler & Sons

Address Union Bridge & New Windsor Md

Dec 31 1945 Received by
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)

Street No. Main Street
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 28 1945 to Dec 31 1945

end that I last saw him alive on Dec 30 1945

Immediate cause of death

Arterio Atherosclerosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE J. H. Legg 22
M. D. or other

Address Union Bridge Date signed 12-31-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12096

1. PLACE OF DEATH:
 Carroll
 County Henryton
 City or town. (If outside city or town limits, write RURAL and give nearest town)
 1 month, 5 days
 How long in above place of death?
 Hospital, Institution, or street address where death occurred:
 Maryland Tuberculosis Sanatorium
 Colored Branch, Henryton, Maryland
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 Maryland County Montgomery
 City or town. (If outside city or town limits, write RURAL and give nearest town)
 Gaithersburg
 Street No. (If rural, give LOCATION)
 2.(a) If veteran, name war.

3. (a) FULL NAME

JAMES WILLIAM BROWN

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced
 male col. widowed

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 6.(c) If alive, give age years
 June 12, 1885

8. AGE: Years Months Days If less than one day
 60 5 28 hrs. min.

9. Birthplace. (Town, county, and state)
 Germantown, Md.

10. Usual occupation. Farm Laborer

11. Industry or business

FATHER 12. Name Jonas Brown
 13. Birthplace Maryland

MOTHER 14. Maiden name Liza Lee
 15. Birthplace Maryland

16. Informant. Reuben Hoffman, M.D.
 Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof. 12/11/45
 Cemetery or crematory. Brownstown Cemetery
 Location. Germantown Md.

18. Funeral director. Dr. Jackie
 Address Gaithersburg Md.

19. Dec. 10, 1945 Albert R. Swank
 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10, 1945 at 7:45 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 5, 1945 to Dec. 10, 1945 and that I last saw him alive on Dec. 10, 1945.

Immediate cause of death. Pulmonary Tuberculosis.

DURATION
 Sept. 1940

Due to.

Due to.

Other conditions.

(Include pregnancy within 3 months of death)

Major findings of operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury. Injured at work?

23. SIGNATURE. Reuben Hoffman, M.D. M. D. or other

Address. Henryton, Md. Date signed 12-10-45

RECEIVED

DEC 19 1945

BUREAU V.E.

THE CORRECT AGE
IS ESPECIALLY IMPORTANT. PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12097

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mos., 20 days.
Hospital, Institution, or street address where death occurred: Maryland
Tuberculosis Sanatorium (Colored)
How long in hospital or institution? same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Mardela Springs, R.R.1.
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)

3. (a) FULL NAME
Juanita Brown

3. (b) Social Security Number
213-14-6807

4. Sex female 5. Color or race colored 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife unknown

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1919 6. (c) If alive, give age _____ years

8. AGE: Years 25 Months 1 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Mardela Springs, Md.
(Town, county, and state)

10. Usual occupation domestic

11. Industry or business

MOTHER FATHER 12. Name Charles O. Brown

13. Birthplace Maryland

14. Maiden name Ruth Hufferton

15. Birthplace Maryland

16. Informant Reuben Hoffman, M.D.

Address Henryton, Md.

17. Burial Burial Date thereof Dec 27, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Federalburg

Location Federalburg, Md.

18. Funeral director J. Hampton & Son

Address Federalburg, Md.

19. Dec. Dec. 24 19 45 Alfred Brown, M.D.
(Date rec'd by registrar) deputy local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1945 at 9:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 1945 to Dec. 24 1945 and that I last saw her alive on December 24 1945

Immediate cause of death _____

Pulmonary tuberculosis DURATION Jan. '45

Due to _____

Due to _____

Other conditions _____

Premature delivery 11-6-45 (Include pregnancy within 3 months of death)

Major findings or operations _____ Date of op. _____

Autopsy results _____ PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

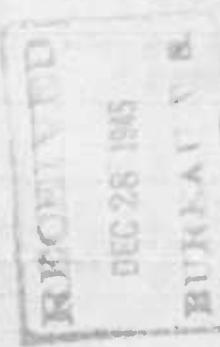
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other _____

Date signed 12-24-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

12098

1. PLACE OF DEATH: Carroll County. Henryton
 City or town. (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months, 5 days
 Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium
 Colored Branch, Henryton, Maryland
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

Maryland Kent
 State County
 Chestertown
 City or town. (If outside city or town limits, write RURAL and give nearest town)
 Street No. 347 Cannon Street
 (If rural, give LOCATION)

3. (a) FULL NAME

JAMES ALBERT BURGESS

3. (b) Social Security Number

218-16-8101

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	col.	single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) October 19, 1923
B. (c) If alive, give age years

8. AGE: Years	Months	Days	It less than one day
22	1	14hrs.min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name John Burgess
 Maryland
 13. Birthplace

MOTHER 14. Maiden name Caroline Carroll
 15. Birthplace Kent County, Maryland

16. Informant Reuben Hoffman, M.D.
 Address Henryton, Maryland

17. Burial Date thereof Dec. 7, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Chestertown
 Location Chestertown, Md.

18. Funeral director Marvin V. Williams
 Address Chestertown, Md.

Dec. 3, 1945 About 8:30 a.m.
 (Date rec'd by registrar)

Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3, 1945, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 28, 1945, to Dec. 3, 1945, and that I last saw him alive on Dec. 3, 1945.

Immediate cause of death Pulmonary Tuberculosis
 DURATION June 1945

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

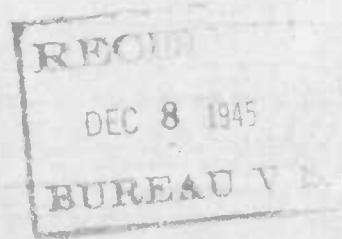
Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE.

Reuben Hoffman, M.D. M. D. or other

Date signed 12-3-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 91

12099

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

Carroll

County..... Sykesville

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 years and 3 months

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 24 years and 3 months

3. (a) FULL NAME

ANNA BYRD

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife.....

(unknown) Byrd

7. Birth date of deceased (mo., day, yr.)

May 28, 1866

8. (c) If alive, give age..... years

8. AGE:

Years
79Months
6 moDays
29

If less than one day

hrs. min.

9. Birthplace.....

West Virginia

(Town, county, and state)

10. Usual occupation.....

none

11. Industry or business.....

none

12. Name.....

Emanuel Mills

13. Birthplace.....

Allegany Co. Md.

14. Maiden name.....

unknown

15. Birthplace.....

Allegany Co. Md.

16. Informant.....

Hospital Records

Address.....

Sykesville, Maryland.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... Jan. 5 1946

(month) (day) (year)

Cemetery or crematory.....

Springfield State Hospital

Location.....

Sykesville, Md.

18. Funeral director.....

C. Harry Eber

Address.....

Sykesville, Md.

19. Date rec'd by registrar.....

Jan. 5 1946

C. Harry Eber.....

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Garrett

City or town..... Pinto

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

December 27 1945

at 9.45 A.M.

20. DATE OF DEATH..... December 19 1921

19. 12-27-1945

and that I last saw her alive on December 26 1945

Immediate cause of death..... General Arteriosclerosis

DURATION

7 yrs.

Due to.....

Due to.....

Other conditions..... Paranoid condition

24 years

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... Maud M. Ross M.D.

M. D. or other

Address..... Sykesville, Md. Date signed 12-27-45

RECEIVED BY TWENTY-THREE STATE CHIEF

RECEIVED BY STAGNITRON



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

12100

Reg. Dist. No. 74

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Carroll County
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
Now long in above place of death? 21 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
Maryland State County
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 32 S. Poppleton Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME
Hannah Josephine Chatterton

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widow

8. (b) Name of husband or wife Ira Chatterton

7. Birth date of deceased (mo., day, yr.) February 1872
8. (c) If alive, give age years

8. AGE: Years 73 Months 10 Days ? If less than one day hrs. min.

8. Birthplace Alexandria, Va.
(Town, county, and state)

10. Usual occupation Seamstress

11. Industry or business

12. Name John Merritt

13. Birthplace Alexandria, Va.

MOTHER FATHER 14. Maiden name Virginia Cawood

15. Birthplace Alexandria, Va.

18. Informant Records of Springfield

Address State Hospital, Sykesville, Md.

17. Burial Date thereof 1945
(Burial, cremation, or removal, Which?) (Month) (day) (Year)

Cemetery or crematory New Cathedral

Location Old Creek Road

18. Funeral director John J. Courtney

Address 901 1/2 Herring St.

19. (Date rec'd by registrar) 1945 (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20 1945 to Dec. 11 1945 and that I last saw her alive on Dec. 11 1945

Immediate cause of death Chronic myocarditis DURATION 5 years

Due to.

Due to.

Other conditions Arterosclerosis DURATION 5 years
(Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John Ramon H. J. M. D. or other

Address Springfield State Ho. (Signed) Dec. 11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12101

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: Carroll
 County Springfield
 City or town Springfield (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 years, 4 months, 9 days
 Hospital, Institution, or street address where death occurred: Springfield State Hospital
 How long in hospital or institution? 8 years, 4 months, 9 days

3. (a) FULL NAME Ray Ruth Cohen
 4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) August 14, 1895 8. (c) If alive, give age years

8. AGE: Years 50 Months 3 Days 23 If less than one day hrs. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation house lady

11. Industry or business

FATHER 12. Name Wolfe Cohen

MOTHER 13. Birthplace unknown

14. Maiden name Sarah Hosquille

15. Birthplace unknown

16. Informant Hospital record

Address Springfield State Hospital

17. Burial Burial Date thereof Dec. 9, 1945 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory United Hebrew Cem.

Location Washington Blvd

18. Funeral director Jack Lewis, Inc.

Address 2100 Eutaw Place

19. Date rec'd by registrar Dec. 7 1945 Dr. Harry Weis Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1727 Allard Ave. (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1945, at 7.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 1942, to December 7 1945 and that I last saw her alive on December 7 1945

Immediate cause of death.....

Bronch pneumonia DURATION 2 days

Due to.....

Due to.....

Other conditions Dementia parvax

18 years (include pregnancy within 3 months of death)

Major findings or operations

Teacher long Date of op. July 1927

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

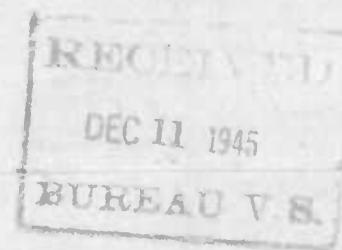
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Louise Hitchman, M.D. M. D. or other

Address Springfield State Hosp. Date signed 12-7-45



1 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

12102

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos. 26 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 3 mos. 26 days

3. (a) FULL NAME

Thomas H. Collins

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	married

6. (b) Name of husband or wife Nellie L. Collins

7. Birth date of deceased (mo., day, yr.) October 10, 1859

8. AGE: Years	Months	Days	if less than one day
86	2	11	hrs. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual occupation Printer

11. Industry or business

12. Name James A. Collins

13. Birthplace North Carolina

14. Maiden name Susan Banner

15. Birthplace North Carolina

16. Informant Records of Springfield State

Address Hospital, Sykesville, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Dec 21 1945

Cemetery or crematory Bethesda Md

Location Wm R. Purple

18. Funeral director Arnold H. Eickert, M.D.

Address Bethesda Md

19. Date 21 1945 C. Harry Eickert
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8400 Georgetown Road

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH December 21 1945 at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 25 1945 to Dec 21 1945

and that I last saw him alive on Dec. 21 1945

Immediate cause of death

Pneumonia (terminal)

Due to Cerebral hemorrhage

Due to Generalized arteriosclerosis

Other conditions Senile Psychotic paranoid type

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arnold H. Eickert, M.D.

M. D. or other

Address 11100 Fylerville Rd. Date signed 12-21-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

12103

Rog. Dist. No. 76

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

Carroll Co. Md
Westminster

(If outside city or town limits, write RURAL and give nearest town)

11 months.

How long in above place of death?

Hospital, institution, or street address where death occurred:

219 E. Main St.

How long in hospital or institution?

3. (a) FULL NAME

William J. Cordle (COROLE)

3. (b) Social Security Number

212-09-4151

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White married.

8. (b) Name of husband or wife

Anne Cremen Cordle

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

Feb. 21, 1889

8. AGE:

Years Months Days 11 less than one day

56

10

8

hrs.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Mechanic

11. Industry or business

Auto Shop

M

OTHER FATHER

12. Name

Wm. J. Cordle

13. Birthplace

Richmond, Va.

MOTHER

14. Maiden name

Catherine Smith

15. Birthplace

Knoxville, Tenn.

16. Informant

Mrs. Anne Cordle

17. Burial

Address 219 E. Main St. Westminster

(Burial, cremation, or removal. Which?)

Date thereof 1/2/46

(month) (day) (year)

Cemetery or crematory

Cathedral Cemetery

Location

Baltimore, Md.

18. Funeral director

L. Vernon Lennan

Address

4611 Park Heights Ave.

19. (Date rec'd by registrar)

1/2/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborns of infants give residence of mother)

State

County

Md. Carroll

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

219 E. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 29-45 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 28-45 to Dec 29-45

and that I last saw him alive on Dec. 29-45

Immediate cause of death

My condition (char)

Due to

Due to

Other conditions

disease (char)

(Include pregnancy within 3 months of death)

Major findings or operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE

W. C. Johnson, M.D.

Washington, D.C. Date signed 12-30-45

DR. Jeannett

111-107000-102-000000

111-107000-102-000000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

12104

CERTIFICATE OF DEATH

74

Reg. Dist. No.

1. PLACE OF DEATH: Carroll
County.....
City or town..... Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 4 months, 3 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland
County.....

City or town..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 548 West Barre Street

(If rural, give LOCATION) ✓

2.(a) If veteran, name war.....

3. (a) FULL NAME

SANFORD DAVIS

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	divorced

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) December 7, 1888

8. AGE: Years	Months	Days	It less than one day
57	0	7hrs.min.

9. Birthplace..... Louisburg, N.C.

(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business

FATHER	12. Name	Samuel Davis
	13. Birthplace	Unknown

MOTHER	14. Maiden name	Leah Harris
	15. Birthplace	Unknown

16. Informant..... Reuben Hoffman, M.D.

Address..... Henryton, Maryland

17. Burial Date thereof..... 12/16/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Mt Calvary

Location..... A & Co Md

18. Funeral director..... Sarah L Brown Son

Address..... 108 W Montgomery Street

19. Dec. 14, 1945
(Date rec'd by registrar)Alfred R. Smith
Deputy Local Registrar

3. (b) Social Security Number
214-01-4818

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14, 1945, at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11, 1944, to Dec. 14, 1945, and that I last saw him alive on Dec. 14, 1945.

Immediate cause of death..... Tuberculous Meningitis

DURATION Nov. 27,

1945

Due to..... Pulmonary Tuberculosis

Jan.

1944

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

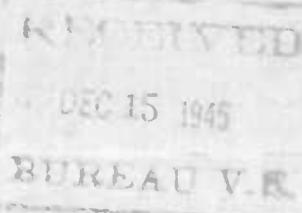
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Reuben Hoffman, M.D.

M. D. or other

Address..... Henryton, Maryland Date signed 12-14-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

12105

CERTIFICATE OF DEATH

74

Reg. Dist. No.

1. PLACE OF DEATH:
County Carroll
City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

2 months, 16 days

How long in above place of death?

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

3. (a) FULL NAME

ROBERT LEE DAY

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife.....

6.(c) If alive, give age.....years

7. Birth date of deceased (mo. day, yr.) September 9, 19288. AGE: Years 17 Months 3 Days 18 If less than one day
.....hrs.min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Scholar

11. Industry or business

12. Name Benjamin Day13. Birthplace Virginia14. Maiden name Alverta Diggs15. Birthplace Virginia16. Informant Reuben Hoffman, M.D.Address Henryton, Maryland17. Burial Date thereof Dec. 31, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Burster RemovalLocation Baltimore, Co. Md.18. Funeral director Mrs. Geo. H. HollandAddress 1631 David Hill Ave.19. Dec. 27, 1945 (Date rec'd by registrar)Abraham Deputy Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Turners Station

(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 Linden Court

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

220-14-2417

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27, 1945 at 2:45 A.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 11, 1945 to Dec. 27, 1945and that I last saw him alive on Dec. 27, 1945

Immediate cause of death

Pulmonary Tuberculosis

DURATION

9-15-45

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

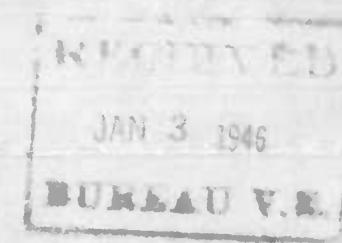
Means of injury.....

Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.

M. D. or other

Address Henryton, Md.Date signed 12-27-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

12106

Reg. Dist. No. 74

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
County..... Carroll
City or town..... Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death..... 1 mo., 9 days.
Hospital, institution, or street address where death occurred:
Springfield State Hosp.
How long in hospital or institution?..... 1 mo., 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County..... Montgomery
City or town..... Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4608 Hunt Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME
Gaetana Del Vecchio

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife..... Dominic Del Vecchio
..... 6.(c) If alive, give age..... unknown years

7. Birth date of deceased (mo., day, yr.)..... July 13 1880
8. AGE: Years Months Days If less than one day

65	4	26	hrs. min.
----	---	----	----------------

9. Birthplace..... Italy
(Town, county, and state)

10. Usual occupation..... housewife

11. Industry or business..... own home

FATHER 12. Name..... Italy Frank Freni
13. Birthplace..... Italy

MOTHER 14. Maiden name..... unknown
15. Birthplace..... Italy

16. Informant..... Hospital records

Address.....

17. Burial (Burial, cremation, or removal. Which?)..... Date thereof..... Dec. 13 1945
(month) (day) (year)

Cemetery or crematory..... Oak Lincoln Cemetery
Location..... Washington, D. C.

18. Funeral director..... J. A. Heiss, Co.

Address..... 1427 St. Washington D. C. 7.20

19. Date rec'd by registrar..... Dec. 10 1945
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 9 1945 6:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1945 to Dec. 9 1945
and that I last saw her alive on Dec. 9 1945

Immediate cause of death.....

Cerebral Hemorrhage

Due to.....

Died to.....

Other conditions.....

Psychosis with Cereb. Art.
(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

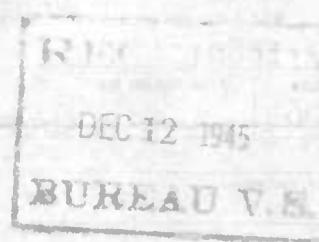
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE..... Arnold H. Elbert M.D. M. D. or other

Address..... 12-Hop. Germantown. Date signed. 12-9-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12167

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

Carroll

County

Sykesville

(If outside city or town limits, write RURAL and give nearest town)

9 days

How long in above place of death?

Springfield State Hospital

9 days

How long in hospital or institution?

3. (a) FULL NAME

John Henry Dietz

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	married

8. (b) Name of husband or wife

Katherine Dietz

7. Birth date of deceased (mo., day, yr.) December 24, 1868

8. AGE: Years	Months	Days	If less than one day
76	11	23	hrs. min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual occupation Gardner

11. Industry or business

FATHER	12. Name	Unknown	Henry Dietz
	13. Birthplace	Maryland	

MOTHER	14. Maiden name	Unknown	Carolina Gault
	15. Birthplace	Unknown	

16. Informant Records of Springfield State Hospital, Sykesville, Md.

17. Burial, cremation, or removal (Watch?) Date thereof Dec 27, 1945

(month) (day) (year)

Cemetery or crematory Maryland Memorial Park

Location Bally Sod.

18. Funeral director Arnold J. Bush

Address 5305 Harford Road.

19. Date rec'd by registrar Dec 17, 1945 C. Henry Baker

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1743 Abbottston Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1945 2:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 8 1945 to December 17 1945

and that I last saw him alive on December 17 1945

Immediate cause of death

Chronic Myocarditis

Due to

Generalized arteriosclerosis

Due to

Other conditions Allergy to right arm

Psychosis & cerebral arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

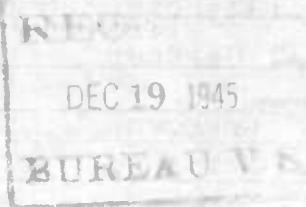
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arnold F. Eichert, M.D.

M. D. or other

Address 111 High, Sykesville, Md. Date signed 12-17-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8th

CERTIFICATE OF DEATH

12108

Reg. Dist. No. 7483

1. PLACE OF DEATH:

County Carroll

City or town New Freedom

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

David Augustus Dorsey

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W

Widowed

B. (b) Name of husband or wife

Edith Anthony

7. Birth date of deceased (mo., day, yr.)

March 5, 1890

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Carroll Co., Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name

William Dorsey

13. Birthplace

Md.

14. Maiden name

Mary A. Leatherwood

15. Birthplace

Md.

16. Informant

Mr. Roland Dorsey

Address

Laurel, Md.

17. ~~Burial~~

(Burial, cremation, or removal. Which?)

Date thereof Dec. 31 1945

(month) (day) (year)

Cemetery Brandenburg Cemetery

Location Berett, Carroll Co., Md.

18. Funeral director

C. Harry New

Address Sykesville, Md.

19. Date rec'd by registrar

Dec. 31 1945

C. Harry New

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Carroll

City or town

Mt. Freedom - P. O. D. 2

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Sykesville P. O.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

#

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 28 1945 at 6:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 26, 1945, to Dec. 28, 1945

and that I last saw him alive on Dec. 28, 1945

Immediate cause of death

Hemiplegia - (left)

DURATION

3 da

Due to Advanced Arterio-~~Sclerosis~~

Sclerosis

? yrs

Due to and Hypertension

? yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Stanley Gralib - M.D.

M. D. or other

Address Mt. Airy, Md. Date signed 12/28/45

RECEIVED IN THE LIBRARY OF THE HOUSE OF COMMONS

1946-1947 SESSION

1946-1947 SESSION

RECEIVED

JAN 10 1946

SURVEYOR

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 330

12109

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County CarrollCity or town Springfield

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Springfield Ave

How long in hospital or institution?

3. (a) FULL NAME

Carrie May Duvall

4. Sex

f.

5. Color or race

w.

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) ? 1883 6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Woodbine Carroll Co. Md.
(Town, county, and state)

10. Usual occupation

house-keeper

11. Industry or business

FATHER

12. Name

George Duvall

13. Birthplace

Carroll Co. Md.

MOTHER

14. Maiden name

Ida Hatfield

15. Birthplace

Carroll Co. Md.

16. Informant

Mrs. Ida Crawford

Address

Westminster Md. R.R. 6

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 12/7/45
(month) (day) (year)

Cemetery or crematory

Morgan Chapel

Location

Woodbine Md.

18. Funeral director

C. M. Waltz

Address

1056 Westminster Md.

19. Date

Dec. 6 1945

(Date rec'd by registrar)

C. M. Waltz

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarrollCity or town Springfield (If outside city or town limits, write RURAL and give nearest town)Street No. Springfield Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4 1945 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1945 to Dec. 4 1945and that I last saw her alive on Dec. 3 1945

Immediate cause of death

Cancer TasmanDue to disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. A. Barnes M.D.

M. D. or other

Address S. B. Barnes M.D. Date signed Dec. 4 1945

RECEIVED

DEC 7 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2d

CERTIFICATE OF DEATH

12110 76
Reg. Dist. No.

P

1. PLACE OF DEATH:

County Carroll Co.
City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Clara S. Eccard.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female white widow.

6.(b) Name of husband or wife

John P. Eccard

7. Birth date of

deceased (mo., day, yr.)

January 30 - 18758. AGE: Years 70 Month Days It less than one day hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

12. Name Calvin main13. Birthplace Maryland14. Maiden name Sarah15. Birthplace Maryland16. Informant Ray EccardAddress 3538 Buena Vista Ave.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Dec 30, 1945
(month) (day) (year)Cemetery or crematory Pleasant HillLocation Frederick Co. Md18. Funeral director Chenoweth & SonowayAddress 3615-17 Chestnut Ave.19. 12/29 19 X5

(Date rec'd by registrar)

A. W. Frederick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll Co.City or town Westminster (If outside city or town limits, write RURAL and give nearest town)Street No. Route 87 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27, 1945 at 11:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 23, 1945 to December 27, 1945and that I last saw h. en alive on December 27, 1945

Immediate cause of death

Broncho-Pneumonia
Leptomenia -

DURATION

4 days
7 days

Due to

Due to

Other conditions Ob. degocardia10 years

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Shuster Bon, M.D.

M. D. or other

Address Westchester New York Date signed 12/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 402

12111

CERTIFICATE OF DEATH

Reg. Dist. No. 15

1. PLACE OF DEATH:

County

City or town

Carroll

Melrose 2nd

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

18 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William J. Eisenhardt

4. Sex

5. Color of Face

6. (a) Single, married, widowed, or divorced

Male White Married

Ellen J. Eisenhardt

B. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 6 - 1880

8. AGE:

Years

Months

Days

If less than one day

65

6

22

hrs.

min.

9. Birthplace

Carroll Co Maryland

(Town, county, and state)

10. Usual occupation

Labor

11. Industry or business

State Road

MOTHER

FATHER

12. Name

Andrew Eisenhardt

13. Birthplace

Germany

14. Maiden name

Margaret Baweran

15. Birthplace

Germany

16. Informant

Ella J. Eisenhardt

Address

Manchester 2nd

17. Burial

Burial Cemetery

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Cemetery

Location

Manchester 2nd

18. Funeral director

Jacob Wicks Sons

Address

Manchester 2nd

19. Date rec'd by registrar

Dec. 29 1945 Mrs. W. B. S. Denner

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

220-10-5859

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 28, 1945 at 5 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 2, 1945 to Dec 28, 1945

and that I last saw him alive on Dec 17, 1945

Immediate cause of death

Carcinoma of Stomach

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. E. Bush M.D.

M. D. or other

Hampstead Md Date signed 12/29/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12112

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH:

Carroll

County

Near Taylorsville

City or town

(If outside city or town limits, write RURAL and give nearest town)

28 years

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

HILDA L. FRANKLIN

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married

William J. Franklin

6. (b) Name of husband or wife

78

years

7. Birth date of deceased (mo., day, yr.)

Sept. 11, 1877

6. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

68

2

30

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Isaac Kiler

FATHER

Maryland

MOTHER

Elizabeth Hooper

14. Maiden name

Maryland

15. Birthplace

Mr. William J. Franklin

16. Informant

Mt. Airy, Md.

Address

Burial

Date thereof 12-3-45

(Burial, cremation, or removal - when?)

(month) (day) (year)

Cemetery or crematory

Taylorsville

Location

Taylorsville, Carroll Co. Md.

18. Funeral director

C. M. Waltz

Address

Winfield, Md.

19. Dec. 2 1945

E. M. Fawcett
Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

County Carroll

City or town near Taylorsville

(If outside city or town limits, write RURAL and give nearest town)

R.D. Mt Airy

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

12/1

1945 at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 2 1945 to December 1 1945

and that I last saw her alive on December 30 1945

Immediate cause of death

Acute Lobar Pneumonia

DURATION

3 days

Due to

C. Lobar Pneumonia

1 year

Due to

Other conditions

5 years

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

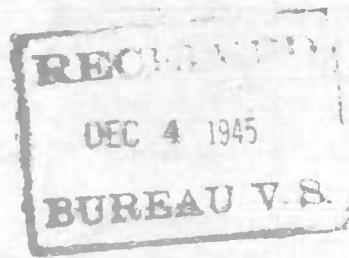
Injured at work?

23. SIGNATURE

D. Fawcett, Esq. (M.D.)

M. D. or other

Address: 12345 12345 Date signed: 12/1/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12114

CERTIFICATE OF DEATH

74

Reg. Dist. No.

1. PLACE OF DEATH:
County Carroll

City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

3 yrs., 2 mos., 15 days

How long in above place of death?

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

3. (a) FULL NAME

THOMAS CHESLEY GRAY

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	col.	single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) May 25, 1911

8. AGE: Years	Months	Days	If less than one day
34	6	25 hrs. min.

9. Birthplace.....
(Town, county, and state)

Musician

10. Usual occupation.....

11. Industry or business.....

12. Name..... James Gray

13. Birthplace..... Calvert County, Md.

14. Maiden name..... Annie Gantt

15. Birthplace..... Calvert County, Md.

16. Informant..... Reuben Hoffman, M.D.

Address..... Henryton, Maryland

17. *Funeral* Date thereof..... 12/24/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... *Mt. Calvary*

Location..... Mt. Calvary, Calvert Co., Md.

18. Funeral director..... Mr. Samuel J. Hensley

Address..... 578 W. Biddle Street, Baltimore

19. Dec. 20, 1945 *Albert A. Johnson*

(Date rec'd by registrar) *Deputy Clerk*

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 25321 Druid Hill Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

155-01-6431

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20, 1945 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 5, 1942, to Dec. 20, 1945

and that I last saw h. im. alive on Dec. 20, 1945

Immediate cause of death..... Pulmonary Tuberculosis

DURATION

April 1942

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE *Reuben Hoffman, M.D.*

M. D. or other

Date signed 12-20-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

CERTIFICATE OF DEATH

12115

Reg. Dist. No. 24

1. PLACE OF DEATH:

County CarrollCity or town Oakland Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yearsHospital, Institution, or street address where death occurred: Oakland Mills P.O.

How long in hospital or institution? _____

3. (a) FULL NAME

Carrie Green4. Sex F.5. Color or race W6. (a) Single, married, widowed, or divorced Married8. (b) Name of husband or wife Harry Green6. (c) If alive, give age 66 years7. Birth date of deceased (mo., day, yr.) July 17, 18858. AGE: Years 60 Months 4 Days 18 If less than one day _____ hrs. _____ min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name John Green13. Birthplace Md.14. Maiden name Mary Shalich15. Birthplace Md.16. Informant Mr. Harry GreenAddress Oakland Mills, Md.17. Burial Date thereof Dec. 9, 1945
(Burial, cremation, or removal. Which?) Date (month) (day) (year)Cemetery or crematory Oakland Methodist ChurchLocation M. Oakland Mills, Carroll Co., Md.18. Funeral director C. Harry GreenAddress Oakland Mills, Md.19. Date rec'd by registrar Dec. 7, 1945(Date rec'd by registrar) C. Harry Green

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County CarrollCity or town Oakland Mills

(If outside city or town limits, write RURAL and give nearest town)

Street No. Sykesville P.O.

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number #

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5, 194521. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 5, 1945 to Dec 5, 1945and that I last saw her alive on Dec 4, 1945Immediate cause of death Acute MalariaDue to Thrombocytopenic purpuraDue to Thrombocytopenic purpura

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings or operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

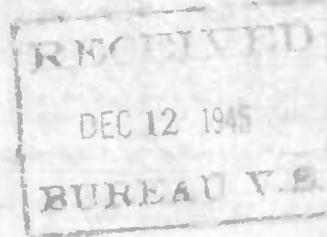
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. B. Barnes, M.D.

M. D. or other _____

Address By funeral home Date signed Dec 5, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. P.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1572

CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH:

County Carroll CoCity or town MT Airy

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mo 20 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

James Edwin Grimes
 4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 16 19458. (c) If alive, give age years

8. AGE: Year 3 Months 20 Days 00 If less than one day hrs. 00 min. 00

9. Birthplace MT Airy Md
(Town, County, and state)

10. Usual occupation.

11. Industry or business

12. Name Roy W. Grimes
 13. Birthplace Taylorville Carroll Co
 14. Maiden name Cora Et Garrison
 15. Birthplace Glenelg Howard Co

16. Informant Mrs Cora Et GrimesAddress MT Airy17. Burial Date thereof 12/18/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory MT OliverLocality Near Mt Airy18. Funeral director C. M. WaltzAddress Winfield MdDec. 8 1945 Thur Duyder

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarrollCity or town MT Airy Md (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1945 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1945 to Dec 7 1945and that I last saw him alive on Dec 7 1945

Immediate cause of death

Congenital Hydrocephalus DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

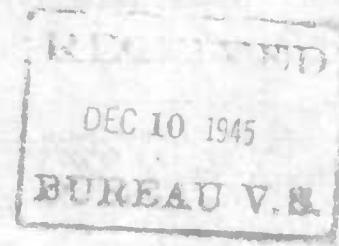
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?23. SIGNATURE Roy Van Foale

M. D. or other

Address MT Airy Date signed Dec 8



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3

12116

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH:

County

Carroll

City or town

Hampstead (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

20 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William M Harris

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M W widowed

6. (b) Name of husband or wife

Mary J Blizzard

7. Birth date of deceased (mo., day, yr.)

Oct 5 - 1883

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

92

2

23

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Ret Farmer

11. Industry or business

Mechanics Harris

FATHER

12. Name

Md

MOTHER

13. Birthplace

Md

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

James Harris

Address

Hampstead, Md

17. Burial

Date thereof

12-30-45
(month) (day) (year)

Cemetery or crematory

Wesley

Location

Carroll Co Md

18. Funeral director

Edw C Tipton

Address

Hampstead Md

19.

Date rec'd by registrar

19

45

John S. Hyatt

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Carroll

City or town

Hampstead (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 28

45

at 9 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 19 45

to

Dec. 28 45

19 45

and that I last saw h. in alive on

Dec. 27 45

19 45

Immediate cause of death

Broncho-pneumonia

DURATION

8 days

Due to

Gripe

x days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Maurice C. Portenier

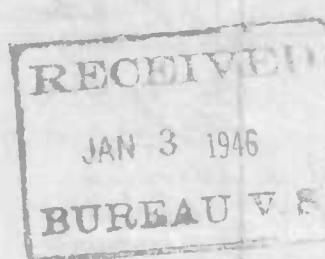
M. D. or other

Address

Hampstead Md

Date signed

Dec. 29 45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

CERTIFICATE OF DEATH

12117

17

Reg. Dist. No.

1. PLACE OF DEATH:
 County Carroll
 City or town Hampstead
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME
Edward T Hauck

4. Sex M 5. Color or race W m. 6. (a) Single, married, widowed, or divorced m.

6. (b) Name of husband or wife Addie M Stansbury

7. Birth date of deceased (mo., day, yr.) Feb 4-1859 6. (c) If alive, give age 82 years

8. AGE: Years 86 Months 10 Days 21 If less than one day

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Ret Farmer

11. Industry or business Henry Hauck

12. Name Henry Hauck
 13. Birthplace Id

14. Maiden name Amanda Lepp

15. Birthplace Id

16. Informant Mrs Russell Williams

Address Hampstead Md

17. Burial Burial Date thereof Dec 28 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hampstead

Location Hampstead Md

18. Funeral director Edd Gipson

Address Hampstead Md

19. Date rec'd by registrar Dec 27 1945 Registar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Carroll
 City or town Hampstead
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1945 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24, 1940 to Dec. 25, 1945 and that I last saw him alive on Dec 23, 1945.

Immediate cause of death _____
Obstruction Myocarditis DURATION _____

Due to _____
Coronary Occlusion Sudden

Other conditions _____
 (Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

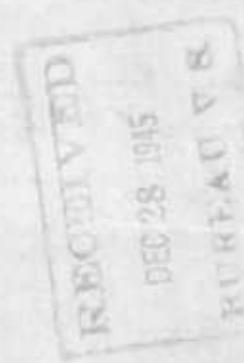
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Jas. E. Bushi M.D. M. D. or other _____

Address Hampstead Md Date signed 12/26/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13-8

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1211876

1. PLACE OF DEATH:

Carroll
County.....rural Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 3½ years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Samuel Andrew Jackson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

widowed

B. (b) Name of husband or wife..... Hester K. Rutter

7. Birth date of deceased (mo., day, yr.)..... July 24, 1855

8. AGE: Years 90 Months 4 Days 29 If less than one day hrs. min.

9. Birthplace..... Philadelphia, Pa.
(Town, county, and state)

10. Usual occupation..... Merchant

11. Industry or business

12. Name..... Samuel A. Jackson

13. Birthplace..... Pennsylvania

14. Maiden name..... Margaret Bower

15. Birthplace..... Pennsylvania

16. Informant..... Frederick R. Jackson

Address..... Westminster, Md.

17. burial..... Date thereof..... 12/28/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Westminster Cemetery

Location..... Westminster, Md.

18. Funeral director..... J. Francis Reese

Address..... Westminster, Md.

19. 12/26/45..... 19..... 19..... 19.....
(Date rec'd by registrar).....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Carroll

City or town..... rural Westminster
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2. (a) If veteran, name war..... none

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 23 1945 at 6 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944 to Dec. 23, 1945

and that I last saw h. i.m. alive on Dec. 23, 1945

Immediate cause of death..... Myocarditis (cln.)

Nephritis (cln.)

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town) (County) (State)

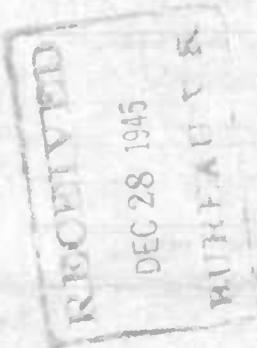
Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... W. C. Jernstedt
M. D. or other

Address..... Westminster, Md. Date signed 12-25-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12119

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County... Carroll

City or town... Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... 5 mos., 17 days

Hospital, Institution, or street address where death occurred: Maryland

Tuberculosis Sanatorium (Colored)

How long in hospital or institution?... same as above

3. (a) FULL NAME

Eddie Jones

4. Sex

male

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

widower

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1902

8. AGE:

Years
43Months
11Days
7

If less than one day

....hrs.

....min.

9. Birthplace..... Portsmouth, Va.

(Town, county, and state)

10. Usual occupation..... Chauffeur

11. Industry or business

FATHER 12. Name..... Amos Jones

MOTHER 13. Birthplace..... Virginia

14. Maiden name..... Cora Grimes

15. Birthplace..... New York

16. Informant..... Reuben Hoffman, M.D.

Address..... Henryton, Md.

17. Removal..... Date thereof..... 12-28-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... University of Maryland

location..... Anatomical Laboratory, Balt.

18. Funeral director..... Mrs. Samalt Jenkins

Address..... 578 W. Buddle St., Balt., Md.

19. 12-26 1945 (Date rec'd by registrar) 12-26 1945 (Date signed)

deputy local

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County.....

City or town..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street..... 1526 E. Pratt Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

167-18-2656

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 26 1945 12:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 9 1945 to Dec. 26 1945

and that I last saw h. im alive on Dec. 26 1945

Immediate cause of death.....

Pulmonary tuberculosis

DURATION

Feb. '45

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

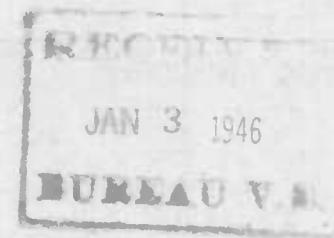
Injured at work?

23. SIGNATURE..... Reuben Hoffman, M.D.

M. D. or other

Address..... Henryton, Md.

Date signed..... 12-26-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2D

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County

City or town

Carroll
Springfield

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 yr 4 mos

Hospital, institution, or street address where death occurred

Springfield State Hospital

How long in hospital or institution?

1 yr 4 mos

3. (a) FULL NAME

Mary E. Kershner

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Jul 17th 1886

8. (c) If alive give age

years

8. AGE: Years

74

Months

9

Days

29

11 less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

Marten Kershner

12. Name

Marten Kershner

13. Birthplace

Md.

14. Maiden name

Susan Miller

15. Birthplace

Md.

16. Informant

J. E. Scott

Address

516 George St. Baltimore

17. Burial

Burial

(Burial, cremation, or removal. Which?)

Date thereof Dec. 19 1945

(month) (day) (year)

18. Cemetery or crematory

Reform cemetery

Location

Salisbury Maryland

19. Funeral director

Fred W. Kershner

Address

Hagerstown Maryland

20. Date rec'd by registrar

Dec. 16 1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

County

Hagerstown

516 George Street

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 16th 1945 at 2-45 a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 4th 1944 to Dec 16th 1945
and that I last saw her alive on Dec 16th 1945

Immediate cause of death

Chronic Hypertension

Dura 10

Due to

Initial regeneration

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide..... Date of 1

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

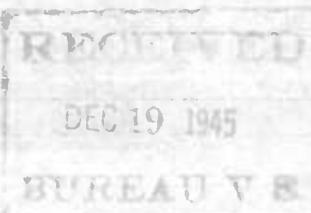
Means of Injury Injured at work?

23. SIGNATURE

M. D. or other

Address

Signature Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

12121

Reg. Dist. No. 75

1. PLACE OF DEATH: Carroll
 County Massachusetts MD
 City or town Massachusetts MD
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years
 Hospital, Institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants, give residence of mother)

State Maryland County Carroll
 City or town Manchester
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME Ida E. Kneller

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
		<u>Edward H. Kneller</u>
B. (b) Name of husband or wife <u>Edward H. Kneller</u>		
7. Birth date of deceased (mo., day, yr.) <u>Jan. 25, 1867</u>		
6. (c) If alive, give age <u>75</u> years		
8. AGE: Years <u>78</u>	Months <u>10</u>	Days <u>28</u>
It less than one day		
hrs. _____ min. _____		
9. Birthplace <u>Manchester</u> <u>MD</u>		
(Town, county, and state)		
10. Usual occupation <u>Housewife</u>		
11. Industry or business <u>John & Lyman</u>		
12. Name <u>John & Lyman</u>		
13. Birthplace <u>Penns</u>		
14. Maiden name <u>Elizabeth Frankfort</u>		
15. Birthplace <u>Maryland</u>		
16. Informant <u>Edward H. Kneller</u>		
Address <u>Manchester</u> <u>MD</u>		
17. Burial <u>Burial</u> Date thereof <u>12-27-45</u> (Burial, cremation, or removal. Which?) <u>(month) (day) (year)</u>		
Cemetery or crematory <u>cemetery</u> <u>U. B.</u>		
Location <u>Manchester</u> <u>MD</u>		
18. Funeral Director <u>Carol Parks' Sons</u>		
Address <u>Manchester</u> <u>MD</u>		
19. Dec. 26 1945 Mrs. H. P. S. Deaver (Date rec'd by registrar)		

3. (b) Social Security Number _____

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 1945 at 10 P.M.
 M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec. 16, 1945, to Dec. 23, 1945,
 and that I last saw her alive on Dec. 23, 1945.

Immediate cause of death General Paralysis duration
 Due to General Paralysis

Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Jas. E. Bush M.D. M. D. or other _____
 Address Medical Md. Date signed 12/26/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

CERTIFICATE OF DEATH

12122 81
Reg. Dlat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

1. PLACE OF DEATH:

County CarrollCity or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Elmer Kobl4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Jennie Elizabeth Kobl7. Birth data of deceased (mo., day, yr.) August 8 - 1863 8. (c) If alive, give age years8. AGE: 82 Years 4 Months 11 Days If less than one day hrs. min.9. Birthplace Frederick Co. Maryland (Town, county, and state)10. Usual occupation Salesman11. Industry or business Retired12. Name Joseph Kobl13. Birthplace Maryland14. Maiden name Annie E. Deen15. Birthplace Maryland16. Informant Mrs. Charles E. GrayAddress Union Bridge, Md.17. Burial Date thereof December 22-1945 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Pike Creek CemeteryLocation Uniontown Road18. Funeral director J. D. Hartley and SonsAddress Union Bridge and New Windsor, Md.19. Dec. 21 1945 (Date rec'd by registrar)Michigan Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarrollCity or town Union Bridge (If outside city or town limits, write RURAL and give nearest town)Street No. Broadway (If rural, give LOCATION)2.(a) If veteran, name war None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 1945 at 10:30 A.M.21. CERTIFY that death occurred on the date above stated: that I attended deceased from November 1945 to December 19 1945 and that I last saw him alive on December 18 1945Immediate cause of death PneumoniaDue to Generalized Arteritis Ocularis yr -

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury James F. Thorpe Injured at work?23. SIGNATURE James F. Thorpe M. D. or otherAddress Waukesha, Wis. Date signed 12-20-45

RECEIVED

JAN 17 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310

CERTIFICATE OF DEATH

Reg. Dist. No. 12123

1. PLACE OF DEATH: Carroll County
 County: Carroll
 City or town: Sparksville 135 days
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 135 days
 Hospital, institution, or street address where death occurred: Springfield State Hosp.
 How long in hospital or institution? 135 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: Maryland County: Cumberland
 City or town: Cumberland 167 Baltimore Street
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.: 167 Baltimore Street
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Paul Lannon

3. (b) Social Security Number

4. Sex: <u>Male</u>	5. Color or race: <u>white</u>	6.(a) Single, married, widowed, or divorced: <u>widowed</u>
---------------------	--------------------------------	---

6.(b) Name of husband or wife: unknown

7. Birth date of deceased (mo., day, yr.): Feby. 11 1909 6.(c) If alive, give age: years

8. AGE: 36 Years 10 Months 14 Days If less than one day: hrs. min.

9. Birthplace: Baltimore Co. (Town, county, and state)

10. Usual occupation: barber

11. Industry or business

MOTHER FATHER

12. Name: John Lannon

13. Birthplace: unknown

MOTHER

14. Maiden name: unknown

15. Birthplace: John Lannon

16. Informant: John Lannon 6
 Address: 167 Baltimore St. Cumberland

17. Burial: Burial Date thereof: Dec. 28, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Cumberland

Location: Cumberland, Md.

18. Funeral director: Louis Spier, Inc.

Address: Cumberland, Md.

19. Date rec'd by registrar: Dec. 25, 1945 P. H. Murphy
 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 25 1945, at 1.50 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1945, to Dec. 24 1945and that I last saw him alive on Dec. 24 1945Immediate cause of death: strangulation

DURATION

3 daysDue to: strangulation

years

Due to: strangulationOther conditions: status asthmaticus

(Include pregnancy within 8 months of death)

Major findings of operations: _____ Date of op. _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where)? _____

Means of injury: _____ Injured at work? _____

23. SIGNATURE: J. L. Lannon M. D. or other: _____Address: Springfield State Hosp. Date signed: 12-25-45

REMADE TO THE UNITED STATES GOVERNMENT
BY THE GOVERNMENT PRINTING OFFICE
1915
CERTIFICATE



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

12124

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
Carroll
County

City or town.....
Henryton

(If outside city or town limits, write RURAL and give nearest town)

21 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

3. (a) FULL NAME

ESTELLE LEARY

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	col.	married

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)
April 7, 1919

8. AGE: Years	Months	Days	If less than one day
26	8	7	hrs. min.

9. Birthplace.....
(Town, county, and state)
Baltimore, Md.

10. Usual occupation.....
Domestic

11. Industry or business.....

FATHER
12. Name.....
Nelson Leary
13. Birthplace.....
Eddington, N.C.

MOTHER
14. Maiden name.....
Annita Gainbry
15. Birthplace.....
Baltimore, Md.

16. Informant.....
Reuben Hoffman, M.D.
Address.....
Henryton, Maryland

17. Burial.....
(Burial, cremation, or removal. Which?)
Date thereof.....
(month) (day) (year)
Mt. Calvary

Cemetery or crematory.....
Location.....
A.O. County
Eloy O. Wilson

18. Funeral director.....
Address.....
1000 Brantley ave

19. Dec. 14, 1945
(Date rec'd by registrar)
Alfred R. Swanson
Deputy Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State.....
Maryland
County.....

City or town.....
Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
1627 Miller Street
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

212-12-5941

MEDICAL CERTIFICATION

20. DATE OF DEATH.....
December 14, 1945, at 12:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov. 23, 1945, to Dec. 14, 1945,
and that I last saw her alive on December 14, 1945.

Immediate cause of death.....

Pulmonary Tuberculosis
DURATION ?

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

Reuben Hoffman, M.D. M. D. or other

Address..... Henryton, Md. Date signed..... 12-14-45

RECEIVED

DEC 19 1945

BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

12125

Reg. Dist. No. 76

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

Carroll

County

Westminster

City or town

(If outside city or town limits, write RURAL and give nearest town)

5 years

How long in above place of death?

Hospital, institution, or street address where death occurred:

M. P. Church Home for the Aged

How long in hospital or institution?

5 years

3. (a) FULL NAME

Philip M. Lemmon

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

married

6. (b) Name of husband or wife

Eva B. Devilbiss

7. Birth date of deceased (mo., day, yr.)

April 7, 1861

(c) If alive, give age 83 years

8. AGE:

Years

Months

Days

If less than one day

84

8

4

hrs.

min.

9. Birthplace

Carroll County, Maryland

(Town, county, and state)

10. Usual occupation

labor

11. Industry or business

Not known

MOTHER FATHER

12. Name

Not known

13. Birthplace

"

"

14. Maiden name

"

"

15. Birthplace

"

"

16. Informant

Mrs. Philip M. Lemmon

Address

Westminster, Md.

17. Burial

Date thereof 12/13/45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Woodlawn Cemetery

Location

Woodlawn, Md.

18. Funeral director

J. Francis Reese

Address

Westminster, Md.

19. (Date rec'd by registrar)

12/11/45

19

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. Main & Church Sts.

(If rural, give LOCATION)

2.(a) If veteran, name war

none

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 11/45

at 30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on December 11/45

Immediate cause of death

Cerebral

DURATION

Hemorrhage

4 days

Due to

General Arterio -

5 yrs

Hypertension

Hypertension

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. Woodward

M. D. or other

Address Westminster, Md. Date signed 12/11/45

RECEIVED

DEC 13 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12126

Reg. Dist. No. 74

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Carroll County, Sykesville, Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 17 days
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 6 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
Maryland State, Baltimore County
City or town: (If outside city or town limits, write RURAL and give nearest town)
Street No. 3416 Lindale Avenue (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME
George W. Leon

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jennifer Leon

7. Birth date of deceased (mo., day, yr.) January 15, 1894 20 days
.....(c) If alive, give age years

8. AGE: Years	Months	Days	If less than one day
51	10	20	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: -----

FATHER 12. Name: Joseph Leon

13. Birthplace: Maryland

MOTHER 14. Maiden name: Marguerite Mahon

15. Birthplace: Maryland

16. Informant: Records of Springfield State

Address: Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal: Which?) Cemetery or crematory: Date thereof: Dec. 8, 1945
(month) (day) (year)

Location: Laurel, Md.

18. Funeral director: William Good, Inc.

Address: 1217 St Paul St.

19. Date rec'd by registrar: Dec. 5 1945 C. G. G. (Signature)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5 1945 at 9:40 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 18, 1945, to December 5, 1945, and that I last saw him alive on December 5, 1945.

Immediate cause of death: General Paralysis of the Insane

Due to: []

Due to: []

Other conditions: []

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op. []

Autopsy results: []

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of []

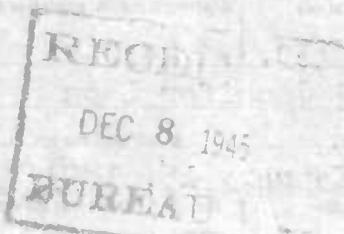
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work? []

23. SIGNATURE: Arnold H. Eichel, M.D. M. D. or other

Address: 111 High Street, Sykesville, Md. Date signed 12-5-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 921

12127

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County..... Carroll

City or town..... Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 25 years

Hospital, institution, or street address where death occurred:

Methodist Home for the Aged

How long in hospital or institution?..... 25 years

3. (a) FULL NAME

Kate L. Lockard

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

white

widow

6. (b) Name of husband or wife.....

Joshua Lockard

7. Birth date of deceased (mn, day, yr.)

June 9, 1855

8. (c) If alive, give age..... years

8. AGE:

Years
90Months
6Days
3

If less than one day

hrs. min.

9. Birthplace.....

Montrose, Baltimore Co., Md.

(Town, county, and state)

10. Usual occupation.....

none

11. Industry or business

12. Name..... John Lloyd

13. Birthplace..... Maryland

14. Maiden name..... Helen Stocksdale

15. Birthplace..... Maryland

16. Informant..... Mrs. George Mather

Address..... Westminster, Md.

17. burial..... Date thereof..... 12/14/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Westminster Cemetery

Location..... Westminster, Md.

18. Funeral director..... J. Francis Reese

Address..... Westminster, Md.

19. (Date rec'd by registrar) 12/12/45 Address..... Registrar.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Carroll

City or town..... Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Main & Church Sts.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

December 12

45

at 5 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on Dec. 5th 1945

Immediate cause of death.....

Coronary

Atherosclerosis

Chronic Myocarditis

Atherosclerosis

DURATION

10 yrs.

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

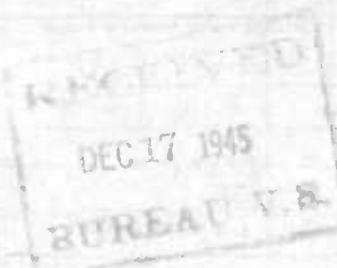
Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or Doctor.....

Address..... Date signed.....



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

12128

Reg. Dist. No. 74

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County

Carroll

City or town

Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 day

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution?

1 yr 1 mo

3. (a) FULL NAME

Emma Gertrude Luhman

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

May 2, 1889

6. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day

56 7 9 hrs. min.

9. Birthplace

(Town, county, and state)

Cumberland

10. Usual occupation

Presser

11. Industry or business

Tailor shop

Alphonse Luhman

12. Name of father

Margaret Hoffman

13. Birthplace

Cumberland

14. Maiden name

Margaret Hoffman

15. Birthplace

Cumberland

16. Informant

Frederick A. Luhman

319 Garrett Ave Cumberland

17. Burial

(Burial, cremation, or removal. Which)

Date thereof (month) (day) (year)

Date thereof Dec 14, 1945

(month) (day) (year)

Cemetery or crematory

St. Peter's and Paul's

Location

Cumberland, Md.

18. Funeral director

Louis Stein Inc.

Address

Cumberland, Md.

19. 12/11/45 19 (Date rec'd by registrar)

C. Harry War

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County Allegany

City or town

Cumberland, Md.

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 11th 1945 72

Dec 9th 1945 19 10 Dec 11th 1945

and that I last saw her alive on Dec 11th 1945

Immediate cause of death

Chronic myocarditis ?

Due to

Tuberculosis pleurisy with effusion ?

Due to

Chronic fibrosis pulmonary tuberculosis ?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

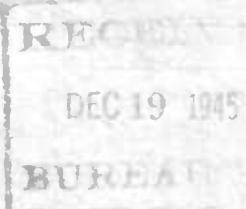
Means of injury

Injured at work?

23. SIGNATURE

H. H. Hagan M. D. *on other*

Address Sykesville Md. Date signed 12/11/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12129

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County CARROLL

City or town RURAL NEAR SYKESVILLE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 yr., 11 mo., 1 day

Hospital, institution, or street address where death occurred:

SPRINGFIELD STATE HOSPITAL

How long in hospital or institution? 24 yr., 11 mo., 1 day

3. (a) FULL NAME

Charles F. Lynch

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE WHITE married

6. (b) Name of husband or wife Laura

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age years

1867

8. AGE: Years Months Days If less than one day

78

?

?

. hrs. . min.

9. Birthplace W. Virginia

(Town, county, and state)

10. Usual occupation laborer

11. Industry or business railroad

12. Name York

13. Birthplace York

14. Maiden name York

15. Birthplace York

16. Informant SPRINGFIELD STATE HOSPITAL RECORDS

Address SYKESVILLE, MARYLAND

17. Burial Date thereof Dec. 10, 1945
(Burial, cremation, or removal? Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director Hafey Funeral Home

Address Cumberland, Md.

19. Dec. 6 1945 C. Harry Gleer

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 232 Arch Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1945 at 3:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to December 6 1945

and that I last saw h. IM alive on December 6 1945

Immediate cause of death Fracture of left hip due to

fall in public institution

DURATION

3 days

Due to:

Due to:

Other conditions Psychosis with cerebral

arteriosclerosis

(Include pregnancy within 3 months of death)

25 years

Major findings or operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 12-3-45

Where did injury occur? Sykesville, Carroll, Maryland

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) institution

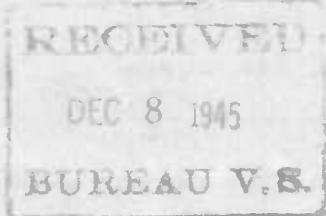
Means of injury fall Injured at work? no

ROBERT BERTRAND MAY, M.D.

23. SIGNATURE Robert Bertrand May, M.D.

SPRINGFIELD STATE HOSPITAL M.D. or other

Address SYKESVILLE, MARYLAND Date signed 12-6-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

12130

CERTIFICATE OF DEATH

Reg. Dist. No.

77

1. PLACE OF DEATH:

County *Carroll*City or town *Syndenburg* Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *15-4 days*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Clinton R Mahanna

4. Sex

5. Color or race *M W S*

6.(a) Single, married, widowed, or divorced

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *Dec 30 - 1997*

6.(c) If alive, give age years

8. AGE:

Years *47* Months *11* Days *24* If less than one day
hrs. min.

9. Birthplace

Town, county, and state *Maryland*

10. Usual occupation

Stone

11. Industry or business

Charles E Mahanna

12. Name

Charles E Mahanna

13. Birthplace

Md

14. Maiden name

Ella Ward

15. Birthplace

Md

16. Informant

Chas A Mahanna

Address

5074 Westminster Md

17. Burial

Date thereof *12-28-45*
(Burial, cremation, or removal. Which?)
(month) (day) (year)

Cemetery or crematory

Emory

Location

Carroll Co Md

18. Funeral director

Taylor C Tipton

Address

Hawthorne Md

19. Date rec'd by registrar

Dec 27 1945 John S. Hughes

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Carroll*City or town *Syndenburg* Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 24 1945 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

*Dec 23, 1945 to Dec 24, 1945*and that I last saw h. ~~im~~ alive on *Dec 23, 1945*

Immediate cause of death

Coronary Bilateral Bronchitis Bronchitis 2 da

Due to

Bronchitis Bronchitis Unknown

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

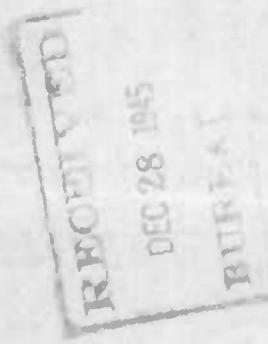
Injured at work?

23. SIGNATURE

Jas. E. Bush Jr. M.D.

M. D. or other

Address *Hawthorne Md*Date signed *12/26/45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH *HC*2411 N. Charles St., Baltimore *BS*

12131

CERTIFICATE OF DEATH

Reg. Dist. No. *74*

1. PLACE OF DEATH:

Carroll

County

City or town Sykesville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos. 18 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 4 mos. 18 days

3. (a) FULL NAME

Hazel Curtis Martin

4. Sex female	5. Color or race white	6. (a) Single, married, widowed, or divorced married
------------------	---------------------------	---

8. (b) Name of husband or wife Robert Daniel Martin

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1921

6. (c) If alive, give age years

8. AGE: Years 24	Months 0	Days 16	If less than one day hrs. min.
---------------------	-------------	------------	---

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Jesse S. Curtis
13. Birthplace Maryland

14. Maiden name Ada Peterson
15. Birthplace Maryland

16. Informant Records of Springfield State Hosp., Sykesville, Md.

Address

17. Burial Date thereof Dec. 16 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Poplar Church Cemetery

Location Warren, Salts. Co. Md.

18. Funeral director William Cook, Jr.

Address 1817 St Paul St.

19. Rec'd by registrar C. Harry Edele

(Date rec'd by registrar) 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore City (If outside city or town limits, write RURAL and give nearest town)

Street No. 3720 Falls Road (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8, 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20, 1945 to December 8, 1945, and that I last saw her alive on December 8, 1945.

Immediate cause of death

Pulmonary Tuberculosis

Due to

Due to

Other conditions Epilepsy without Psychosis, Mental Deficiency (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

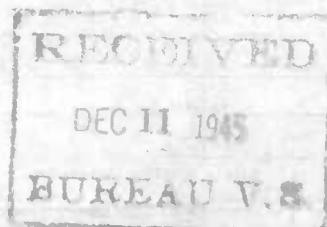
23. SIGNATURE Arnold H. Eichert M.D.

M. D. or other

Address S. S. Hosp., Sykesville, Md. Date signed 12-8-45

RECEIVED IN THE LIBRARY OF THE STATE OF PENNSYLVANIA

BY THE ATTORNEY GENERAL



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1915

12132

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Rosedale Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 68 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William David Martin

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Edna Belle Frank

6. (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) July 8

1882

8. AGE:

Years 63

Months 4

Days 26

If less than one day

hrs.

min.

9. Birthplace Carroll Co. Md.

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER

12. Name David Martin

13. Birthplace Carroll Co. Md.

14. Maiden name Virginia Morelock

15. Birthplace Carroll Co. Md.

16. Informant William F. Martin

Address

Westminster Md. Ft 4

17. Burial

Date thereof Dec. 7 1945

(Burial, cremation, or removal, Which?)

Cemetery or crematory Ridder

Location

Westminster Md.

18. Funeral director

B. Bankard & Son

Address

Westminster Md.

19. Date rec'd by registrar

1945

Signature of Registrars

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 4 1945 1945 at 9:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 25 1945 to Dec 4 1945 and that I last saw deceased on Dec 3 1945

Immediate cause of death cerebral hemorrhage

Due to chronic bronchitis 2 yrs

nephritis

Due to arteriosclerosis 4 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

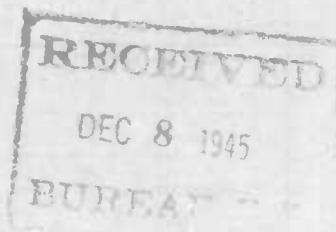
Injured at work?

23. SIGNATURE

Chas R. Frost MD

M. D. or other

Address Westminster Md Date signed 12-5-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-1

12133

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

1 month, 18 days

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland

How long in hospital or institution?

3. (a) FULL NAME

JOSEPH BERNARD MATTHEWS

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	col.	married

6. (b) Name of husband or wife..... York -

6. (c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.) June 3, 1908

8. AGE: Years	Months	Days	If less than one day
37	6	15	hrs. min.

9. Birthplace California, Md. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Alvin Matthews

13. Birthplace St. Mary's County, Md.

14. Maiden name Ella Dawson

15. Birthplace California, Md.

16. Informant Reuben Hoffman, M.D.

Address Henryton, Maryland

17. Burial Date thereof 12-21-45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Grace

Location Great Mills, Md.

18. Funeral director W.C. Maltzinger Sons

Address Leonardtown, Md.

19. Dec. 18, 1945 Albert R. Swankham

(Date rec'd by registrar) Deputy Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland St. Mary's County

City or town California (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

200-10-1308

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 1945 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 31, 1945 to Dec. 18, 1945

and that I last saw h. im. alive on Dec. 18, 1945

Immediate cause of death Pulmonary Tuberculosis

DURATION July 1, 1945

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

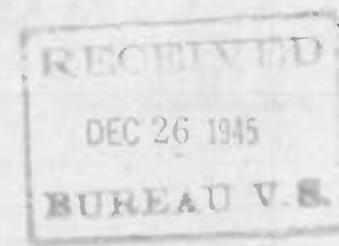
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Address Henryton, Md. Date signed 12-18-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12134

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mos. 18 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 5 mos. 18 days

3. (a) FULL NAME

Rose Matz

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Louis Matz

7. Birth date of deceased (mo., day, yr.)

January 1898

6. (c) If alive, give age years

8. AGE:

Years 47

Months 11

Days ?

If less than one day

..... hrs. min.

9. Birthplace

Boston, Mass.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name Max Shear

MOTHER

13. Birthplace Russia

MOTHER

14. Maiden name Dora

MOTHER

15. Birthplace Russia

16. Informant

Records of Springfield State

Address

Hospital, Sykesville, Md.

17. Burial

(Burial, cremation, or removal; which?)

Date thereof 12-24-45
(month) (day) (year)

Cemetery or crematory

Rosedale

Location

Hamilton Ave

18. Funeral director

Jack Lewis Inc

Address

2100 Eutaw Place

19. Date rec'd by registrar

Dec. 22 1945

C. Harry Weller

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1562 North Fulton Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22

1945, at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 4 1945, to December 22, 1945, and that I last saw him alive on December 22, 1945.

Immediate cause of death

Chronic Myocarditis

Due to

Due to

Other conditions

Schizophrenia Paranoid type

5 years

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Arnold H. Eichert, M.D.

M. D. or other

Address 1110 E. 36th St., Sykesville, Md. Date signed 12-22-45





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3a

12135

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH: Carroll

County.

City or town. New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Burial

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME Fannie A. Neodemus

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white widowed

6. (b) Name of husband or wife late Charles Neodemus

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age years

June 3 - 1864

8. AGE:

Years

Months

Days

If less than one day

8

11 6

22

hrs.

min.

9. Birthplace

(Town, county, and state) Frederick County, Md.

10. Usual occupation

Housekeeper

11. Industry or business

Thomas Leggall

12. Name

Thomas Leggall

13. Birthplace

Maryland14. Maiden name Ann M. Poole15. Birthplace Maryland16. Informant Mrs. Margaret PearceAddress New Windsor, Md17. Burial Burial Date thereof Dec. 28 - 1945

(Burial, cremation, or removal? Which?) (month) (day) (year)

Cemetery Union CemeteryLocation Elmwood, Md18. Funeral director H. H. Haithley & SonsAddress Union Bridge, New Windsor, Md19. Date rec'd by registrar Dec 27 1945 Date signed Dec 27 1945

(Date rec'd by registrar) (Date signed)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town New Windsor

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 25

1945, at 4:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1 to Dec 25 1945and that I last saw her alive on Dec 24 1945

Immediate cause of death

Pneumonia, Bronchitis

Due to

Central Hemorrhage

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

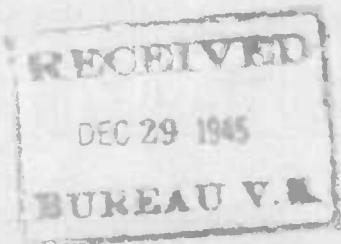
Means of injury

Injured at work?

23. SIGNATURE S. A. Legg

M. D. or other

Address Union BrookDate signed Dec 27 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1241

CERTIFICATE OF DEATH

12136

Reg. Dist. No. 76

1. PLACE OF DEATH:

County..... Carroll

City or town..... near East View

(If outside city or town limits, write RURAL and give nearest town)

37 years

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Laban Garfield Ogg

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

married

8. (b) Name of husband or wife..... Nellie M. Niner

7. Birth date of deceased (mo., day, yr.)

October 18, 1880

8. (c) If alive, give age 53 years

8. AGE:

Years

Months

Days

If less than one day

65

1

26

hrs.

min.

9. Birthplace..... Carroll County, Maryland

(Town, county, and state)

10. Usual occupation.....

farmer

11. Industry or business

12. Name..... George W. Ogg

13. Birthplace..... Maryland

MOTHER FATHER

14. Maiden name..... Laura F. Williams

15. Birthplace..... Maryland

16. Informant..... Mrs. Laban G. Ogg

Address

Westminster, Md. R.D.

17. burial

(Burial, cremation, or removal. Which?)

Date thereof..... 12/17/45

(month) (day) (year)

Cemetery or crematory..... Deer Park Cemetery

Location.....

Smallwood, Md.

18. Funeral director..... J. Francis Reese

Address

Westminster, Md.

19. 12/15/45

19.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Carroll

City or town..... near East View

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

none

3. (b) Social Security Number..... none

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 14 1945 at 11 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11-30-1944 to 12-14-1945

and that I last saw him alive on 12-14-1945

Immediate cause of death.....

Cardiac Decompensation

Portal Cirrhosis

Buta. Chl. Nephritis

DURATION

1 1/2 yrs

1 1/2 yrs

1 1/2 yrs

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... none

Date of op.

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

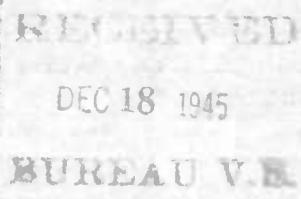
Injured at work?

23. SIGNATURE..... J. D. Caples

M. D. or other

Address. Reisterstown, Md.

Date signed. 12-15-45



CERTIFICATE OF DEATH

1. PLACE OF DEATH: Carroll County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)		
rural near Sykesville			Maryland..... County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)		
How long in above place of death? 2 yr., 7 mo., 15 days			Street No. (If rural, give LOCATION)		
Hospital, institution, or street address where death occurred: Springfield State Hospital			2. (a) If veteran, name war.....		
How long in hospital or institution? 2 yr., 7 mo., 15 days			3. (b) Social Security Number		
3. (a) FULL NAME John O'Halleran			MEDICAL CERTIFICATION		
4. Sex male		5. Color or race white	6. (a) Single, married, widowed, or divorced unknown		20. DATE OF DEATH December 14 1945, at 4:00 a.m.
6. (b) Name of husband or wife.....			21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 13 1943, to Dec. 14 1945 and that I last saw h. im. alive on December 13 1945		
7. Birth date of deceased (mo., day, yr.) 1888 (?) 1875?			6. (c) If alive, give age..... years		
8. AGE: Years appears to be 70			Months	Days	If less than one day hrs. min.
9. Birthplace Pennsylvania (Town, county, and state)			IMMEDIATE CAUSE OF DEATH Arteriosclerosis		
10. Usual occupation laborer			DURATION 4 year		
11. Industry or business			DUE TO		
12. Name Patrick O'Halleran			DUE TO		
13. Birthplace Ireland			OTHER CONDITIONS Psychosis with cerebral arteriosclerosis (Include pregnancy within 3 months of death)		
14. Maiden name Mary O'Leary			MAJOR FINDINGS OF OPERATIONS Date of op.		
15. Birthplace Ireland			AUTOPSY RESULTS PHYSICIAN: Please underline the cause to which death should be charged statistically.		
16. Informant Springfield State Hosp. records			22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of.....		
Address Sykesville, Maryland			Where did injury occur? (City or town) (County) (State)		
17. Burial..... Date thereof Dec. 17 1945 (Burial, cremation, or removal. Which?) (month) (day) (year)			Injured at home, farm, industry, public place (where?)		
Cemetery or crematory Springfield Corp Cemetery			MEANS OF INJURY Injured at work?		
Location Sykesville, Md.			23. SIGNATURE Robert Bertrand May, M.D.		
18. Funeral director C. Harry Wier			Springfield State Hospital M. D. or other		
Address Sykesville, Md.			Address Sykesville, Maryland Date signed 12-14-45		
19. Dec. 17 1945 C. Harry Wier (Data rec'd by registrar)					
			Registrar		

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct information is especially important. Physicians: please write the causes of death clearly and legibly.

11

VS A15

RECEIVED

DEC 19 1945

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12138

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

2 months

How long in above place of death?

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

3. (a) FULL NAME

ROSA PERVIS

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	widowed

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) September 15, 1903

6.(c) If alive, give age.....years

8. AGE: Years	Months	Days	If less than one day
42	2	18	hrs. min.

9. Birthplace.....
(Town, county, and state)

Rocky Mountain, N.C.

10. Usual occupation.....

Factory Worker

11. Industry or business

12. Name	Andrew May
13. Birthplace	North Carolina

14. Maiden name	Martha Scarborough
15. Birthplace	North Carolina

16. Informant.....

Reuben Hoffman, M.D.

Address Henryton, Maryland

17. Burial Date thereof Dec. 6, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Calvary

Location Annapolis Rd.

16. Funeral director Mrs. Robert Elliott, 9 daughter

Address 1129 N. Caroline St.

19. Dec. 3, 1945 Allentown, Pa.

(Date rec'd by registrar) Deputy Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1031 N. Portland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

217-01-5936

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3, 1945, at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 3, 1945, to Dec. 3, 1945, and that I last saw her alive on December 3, 1945.

Immediate cause of death

Pulmonary Tuberculosis DURATION Feb. 1, 1942

Due to.....

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Address Henryton, Maryland Date signed 12-3-45

RE

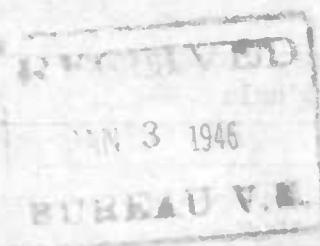
DEC 5 1945

BUREAU V. S.

RECEIVED

DEC 5 1945

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20

12140

CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH: Carroll

County Rural--Mt. Airy

City or town (If outside city or town limits, write RURAL and give nearest town)

27 years

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

OLIVER D. RIDGELY

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Widowed

6.(b) Name of husband or wife Ida M. Ridgely
Deceased

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1850

8. AGE: Years Months Days If less than one day
95 3 2 hrs. min.9. Birthplace Howard Co. Maryland
(Town, county, and state)

10. Usual occupation Farmer (retired)

11. Industry or business

12. Name Henry K. Ridgely

13. Birthplace Maryland

14. Maiden name Achah Dorsey

15. Birthplace Maryland

16. Informant Mr. Charles W. Ridgely

Address Mt. Airy, Md.

17. Burial Date thereof 12-28-45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Mt. Olive

Cemetery or crematory

Location Mt. Olive, Carroll Co. Md.

18. Funeral director C. M. Waltz

Address Winfield, Md.

19. Date rec'd by registrar Dec. 27 1945 I. M. D. Ridgely

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural--Mt. Airy

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1945 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. alive on 19. to 19.

and Immediate cause of death General Arteritis pellagrae

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations None Date of op.

Autopsy results None Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James & Mabel Deputy Justice of the Peace

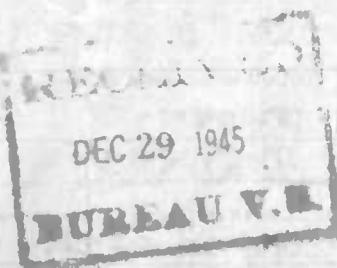
M. D. or other

Address Washington, D. C. Date signed 12-26-45

(Date rec'd by registrar)

RECORDED IN THE STATE OF TEXAS

RECORDED IN THE STATE OF TEXAS



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8301

CERTIFICATE OF DEATH

Reg. Diat. No. 1214176

1. PLACE OF DEATH: Carroll
 County: Carroll
 City or town: Westminster
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
 Hospital, Institution, or street address where death occurred: 109 W. Main St.

How long in hospital or institution?.....

3. (a) FULL NAME Maggie S. Robertson

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife James J. Robertson

7. Birth date of deceased (mo., day, yr.) April 21 - 1869 6. (c) If alive, give age years

8. AGE: Years 76 Months 7 Days 26 If less than one day hrs. 00 min. 00

9. Birthplace Carroll County, Md. (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business Pine Baby Linen

FATHER 12. Name Maryland

13. Birthplace Missouri, Purchase

MOTHER 14. Maiden name Maryland

15. Birthplace Missouri, Purchase

16. Informant Margaret Robertson

Address 109 W. Main St. Westminster

17. (Burial, cremation, or removal. Which?) Burial Date thereof Dec. 19 - 1945 (month) (day) (year)

Cemetery or crematory Baptist Cemetery

Location Genesee Town Road

18. Funeral director A. D. Hartley & Sons

Address Elmwood Budget & New Elmdorff

19. (Date rec'd by registrar) 12/19/45 1945 Alfred (Signature) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
 State: Maryland County: Carroll
 City or town: Westminster
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 109 W. Main St. (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 1945 at 10:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 15 - 1945 to Dec. 17 - 1945 and that I last saw her alive on Dec. 16 - 1945.

Immediate cause of death Stroke. Hemorrhage DURATION 3 days

Due to Cerebral Hemorrhage DURATION 2 mos.

Due to arteriosclerosis DURATION 5 yrs.

Other conditions..... (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Charles R. Denton M. D. or other

Address Westminster, Md. Date signed 12/17/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

12142

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH: Carroll
County.....

City or town..... rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 yr., 9 mo., 27 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 37 yr., 9 mo., 27 days

3. (a) FULL NAME

John Rogg

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) unknown 1897

8. AGE: Years	Months	Days	If less than one day
68 (?)	?	?	hrs. min.

9. Birthplace..... Pennsylvania
(Town, county, and state)

10. Usual occupation..... laborer

11. Industry or business

MOTHER FATHER	12. Name..... York -
	13. Birthplace..... Pennsylvania

MOTHER	14. Maiden name..... York -
	15. Birthplace..... Maryland

16. Informant..... Springfield State Hosp. records

Address..... Sykesville, Maryland

17. Burial..... Date thereof..... Dec. 18, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Springfield Hosp. Crem.

Location..... Carroll, Maryland

18. Funeral director..... C. Harry Weer

Address..... Sykesville, Maryland

19. Dec. 18, 1945 C. Harry Weer
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore City
(If outside city or town limits, write RURAL and give nearest town)Street No..... York -
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 17 1945, at 7:20 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 1 1943, to Dec. 17 1945
and that I last saw him alive on December 17 1945Immediate cause of death..... Chronic myocarditis and myocardial degeneration
DURATION..... 2 yrs.

Due to.....

Due to.....

Other conditions..... Psychosis with mental deficiency
(Include pregnancy within 3 months of death) 40 years

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE..... Robert Bertrand May, M.D. or other

Springfield State Hospital M. D. or other

Address..... Sykesville, Maryland Date signed 12-17-45

RECEIVED

DEC 20 1945

BUREAU V.E.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

CERTIFICATE OF DEATH

Reg. Dist. No. 76

12143

1. PLACE OF DEATH: Carroll Co.
County Carroll Co.

City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years

Hospital, Institution, or street address where death occurred: 146 W. Main St.

How long in hospital or institution?

3. (a) FULL NAME Josie Myers Russell

4. Sex f 5. Color or race w. 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Frank J. Russell

7. Birth date of deceased (mo., day, yr.) April 26, 1871 8. (c) If alive, give age years

8. AGE: Years 74 Months 7 Days 18 If less than one day hrs. min.

9. Birthplace Fred Co. Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

MOTHER FATHER 12. Name John W. Myers

13. Birthplace Fred Co. Md.

14. Maiden name Alici Sidwell

15. Birthplace Fred. Co. Md.

16. Informant Mrs. Sarah M. Bennett

Address 146 W. Main St. Westminster Md.

17. Burial Date thereof 12/16/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Friends Cemetery

Location Union Bridge Md.

18. Funeral director J. E. Myers Jr.

Address Westminster Md.

19. (Data rec'd by registrar) 12/15/45 JK Woodward JK Woodward

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll Co.

City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No. 146 W. Main St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14/45 1945, at 10:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 8 1945 to Dec 14 1945

and that I last saw h. alive on Dec. 14 1945

Immediate cause of death Cerebral Thrombosis - DURATION 1 wk.

Due to General Arterio-
Tclerosis.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

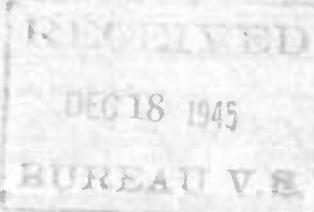
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE JK Woodward M. D. or other

Address Westminster Md. Date signed 12/15/45

STANDARD TELEGRAPHIC STATE CHARTERED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

12144

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 4 mos., 22 daysHospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium (Colored)How long in hospital or institution? same as above

3. (a) FULL NAME
Walter Seay

4. Sex <u>male</u>	5. Color or race <u>colored</u>	6. (a) Single, married, widowed, or divorced <u>single</u>
-----------------------	------------------------------------	---

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) August 20, 1915

8. AGE: Years <u>30</u>	Months <u>4</u>	Days <u>6</u>	If less than one dayhrs.min.
----------------------------	--------------------	------------------	---

9. Birthplace Sparrows Point, Md.
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name <u>William Seay</u>
13. Birthplace <u>Unknown</u>

MOTHER FATHER	14. Maiden name <u>Susie Johnson</u>
	15. Birthplace <u>Appomatox, Va.</u>

16. Informant Reuben Hoffman, M.D.Address Henryton, Md.17. Burial Date thereof Dec. 30-43
(Burial, cremation, or removal. Which?) Date thereof
(month) (day) (year)Cemetery or crematory Mt. CalvaryLocation 2 A. Co. 3rd18. Funeral director Sam'l J. Chase Wm.Address 658. 7th Gilmer19. Dec. 26 1945 (Date rec'd by registrar) Albert R. Swallow Deputy local

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Sparrow Point
(If outside city or town limits, write RURAL and give nearest town)Street No. 623 I Street
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number
none

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1945 5:20 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 4 1943, to Dec. 26 1945, and that I last saw Jim alive on Dec. 26 1945.Immediate cause of death Pulmonary tuberculosis DURATION Jan. 43

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

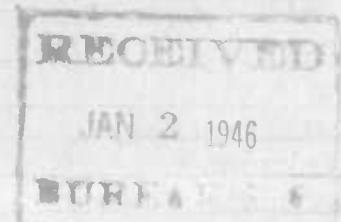
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or otherAddress Henryton, Md. Date signed 12-26-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1314

CERTIFICATE OF DEATH

12145

82

Reg. Dist. No.

1. PLACE OF DEATH: Carroll
 County
 City or town Mt. airy Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Carroll
 City or town Mt. airy
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)

3. (a) FULL NAME

Alice PearceSponsella

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Ch. F. Pearce Sponsella
 deceased
 6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1881

8. AGE: Years 64 Months 8 Days 23 If less than one day hrs. min.

9. Birthplace Virginia
 (Town, county, and state)

10. Usual occupation House work

11. Industry or business John Bowie

FATHER 12. Name John Bowie
 13. Birthplace Virginia

MOTHER 14. Maiden name Helen Pett
 15. Birthplace Virginia

16. Informant Mrs. Harold Johnson
 Address Mt. airy, Md

17. (Burial, exhumation, or removal. Which?) Burial Date thereof 12-26-45
 (month) (day) (year)

Cemetery or crematory Pine Grove
 Location Mt. airy, Carroll Co. Md

18. Funeral director C. M. Wall
 Address Winfield, Md

19. Date rec'd by registrar Dec. 26 1945 Thur D. Snyder
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24, 1945 at 3:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1943 to Dec. 24 1945 and that I last saw h. h. alive on December 24 1945.

Immediate cause of death Cardiac Decompensation
 and 6 hr. Uremia

Due to 6 hr. Myocarditis
 and 6 hr. Interstitial Nephritis

Due to
 Other conditions Ch. Hypertension
Arterio - Sclerosis

(Include pregnancy within 3 months of death) 3 yrs
3 yrs

Major findings of operations none Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE J. Stanley Grubell
 M. D. or other
 Address Mt. airy, Md Date signed 12/24/45



PLEASE WRITE PLAINLY, WITH DNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 76

12146

1. PLACE OF DEATH:

County Carroll Co.

City or town Rural near Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months + 3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Elizabeth Reichel Spreed

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

f.

W.

Widowed

6. (b) Name of husband or wife Fred Spreed

7. Birth date of deceased (mo. day. yr.)

Jan 28 1870

6. (c) If alive, give age..... years

8. AGE:

Years
75Months
11Days
2

If less than one day

hrs.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

MOTHER FATHER

12. Name

Reichel

13. Birthplace

Germany

14. Maiden name

?

15. Birthplace

Germany

16. Informant

Mrs. Donald W. Doss

Address

Westminster Rd. 37 N.d.

Burial

(Burial, cremation, or removal. Which?)

Date thereof. (month) (day) (year)

Cemetery or crematory

Meadow Bluff

Location

Near Westminster, Md.

18. Funeral director

J. S. Myers Jr.

Address

Westminster, Md.

19. (Date rec'd by registrar)

19. 46

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Carroll

City or town Rural near Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7000 Ridgeway Mill

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 31 1945 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 15 1945 to Dec. 31 1945

and that I last saw her alive on Dec. 31 1945

Immediate cause of death

Myocardial degeneration

Due to

Arteriosclerosis

Due to

Arteriosclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

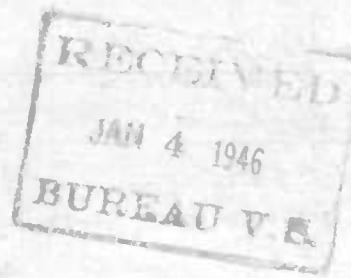
Injured at work?

23. SIGNATURE

E. Roosevelt Wilkins

M. D. or others

Westminster, Md. Date signed 12/31/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Distr. No. 74

12147

1. PLACE OF DEATH:
County..... Carroll
City or town..... Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 8 months, 4 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County.....
City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2431 Madison Avenue
(If rural, give LOCATION)

3. (a) FULL NAME
BEATRICE STEWART

3. (b) Social Security Number
217-20-4775

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced		
female	col.	married		
6. (b) Name of husband or wife..... Paul Stewart				
7. Birth date of deceased (mo. day, yr.)..... January 26, 1921				
6. (c) If alive, give age..... 25 years				
8. AGE:	Years	Months	Days	If less than one day
	24	10	6	hrs. min.
9. Birthplace..... Baltimore, Md.				
(Town, county, and state)				
10. Usual occupation..... Housewife				
11. Industry or business.....				
MOTHER FATHER	12. Name..... Joseph Carter			
	13. Birthplace..... Bowie, Maryland			
14. Maiden name..... Myrtle Short.				
15. Birthplace..... Charles County, Maryland				
16. Informant..... Reuben Hoffman, M.D.				
Address..... Henryton, Maryland				

17. Burial..... Date thereof..... 12-7-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Arbutus Memorial Park
Location..... 3000 Arbutus Road, Arbutus, Maryland
18. Funeral director..... Albert R. Swank, Jr.
Address..... 1631 Drift Hill Ave
Dec. 2, 1945

19. (Date rec'd by registrar) Dec. 2, 1945
Deputy Loc... Albert R. Swank, Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 2, 1945 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28, 1945, to Dec. 2, 1945, and that I last saw her alive on Dec. 2, 1945.

Immediate cause of death..... Pulmonary Tuberculosis

DURATION..... Feb. 1, 1945

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

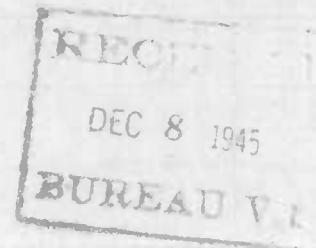
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Reuben Hoffman, M.D. M.D. or other
Address..... Henryton, Maryland Date signed..... 12-2-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12148

CERTIFICATE OF DEATH

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Carroll

near Manchester (Rural)

30

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Bessie May Stoffle

4. Sex

5. Color or race

b. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband

Horatio G. E. Stoffle

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

59

years

June 24, 1888

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

House Work

11. Industry or business

MOTHER FATHER

12. Name

Eli J. Yingling

13. Birthplace

Maryland

14. Maiden name

Eustina J. Zeph

15. Birthplace

Penns

16. Informant

Horatio G. E. Stoffle

Address

Manchester Md

Burial

Burial

Date thereof (month) (day) (year)

Cemetery or crematory

Cemetery

Location

Lester Church

16. Funeral director

Funeral R. J. Whipple

Address

Manchester Md

17. (Date rec'd by registrar)

Dec. 23 1945 Mrs. H. R. J. Deemer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 21 1945 1:00 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Oct.

1945 Dec. 21 1945

and that I last saw him alive on

Immediate cause of death

cardiac fibrillation

Due to

cardiac

Due to

artery sclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12149

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH: Carroll
County Carroll

City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Rural
Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME Samuel Young Stuller

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Sarah Kemper

7. Birth date of deceased (mo., day, yr.) Jan. 18 - 1863 8. (c) If alive, give age years

8. AGE: 82 Years 11 Months 13 Days If less than one day hrs. min.

9. Birthplace Carroll County, Md.
(Town, county, and state)

10. Usual occupation farmer

11. Industry or business

MOTHER FATHER 12. Name John Stuller

13. Birthplace Maryland

14. Maiden name Leah Young

15. Birthplace Maryland

16. Informant Mrs. B. Waddell

Address New Windsor, Md. R. D.

Burial Cemetery Burial Date thereof Jan. 2-1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Windsor Cemetery

Location Westminster, Md. R. D.

18. Funeral director W. H. Hartley & Sons

19. John Burge New Windsor, Md.

Jan 2 1945 Ernest B. Bonde
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31 1945 at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 29 1945 to Dec. 31 1945 and that I last saw him alive on December 30 1945

Immediate cause of death Labor & pneumonia DURATION 2 day

Due to:

Due to:

Other conditions arterio sclerosis L-V disease
(Include pregnancy within 3 months of death)

Major findings of operations:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

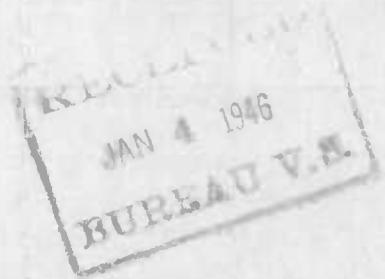
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James & Mabel M. S. M. D. or other

Address Westminster, Md. Date signed 12-31-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12150

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

Carroll

County

Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 3 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 1 month, 3 days

3. (a) FULL NAME

George W. Taylor

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife Not known

7. Birth date of deceased (mo., day, yr.)

July 14, 1901

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

44

5

4

hrs.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation Tanner

11. Industry or business

12. Name Joseph H. Taylor

13. Birthplace Maryland

14. Maiden name Rebecca Barber

15. Birthplace Maryland

16. Informant Springfield State Hospital,

Address Sykesville, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Dec 23 45

(month) (day) (year)

Cemetery or crematory Cemetery Greenbush

Location 91 illuminated

18. Funeral director Edie

Address Williamsport Md

19. Dec 20 1945

(Date rec'd by registrar)

C. Harry Lee

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Washington

City or town Williamsport

(If outside city or town limits, write RURAL and give nearest town)

Street No. -----

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 1945 at 11:30 M a

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 16 1945 to Dec. 19 1945

and that I last saw him alive on December 19 1945

Immediate cause of death

Pneumonia

Due to

Influenza

Due to

Other conditions Psychotic condition

Meningo-encephalitis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Arnold H. Eichert M.D.

M. D. or other

Address 11 Hop. Sykesville, Md. Date signed 12-19-45

RECEIVED

DEC 26 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

CERTIFICATE OF DEATH

Reg. Dist. No. 1215176

1. PLACE OF DEATH:

County..... Carroll
City or town..... rural Patapsco

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Laura Jane Taylor

3. (b) Social Security Number
none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	widow

6. (b) Name of husband or wife..... David E. Taylor

7. Birth date of deceased (mo., day, yr.)..... 6. (c) If alive, give age..... years
October 11, 18688. AGE: Years Months Days If less than one day
77 2 6 hrs. min.9. Birthplace..... Carrollton, Maryland
(Town, county, and state)

10. Usual occupation..... none

11. Industry or business

12. Name..... William Blizzard

13. Birthplace..... Maryland

14. Maiden name..... Susanne Wisner

15. Birthplace..... Maryland

16. Informant..... Mrs. Ada M. Kidd

Address..... Patapsco, Md.

17. burial..... Date thereof..... 12/19/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Bethel Cemetery

Location..... Carrollton, Md.

18. Funeral director..... J. Francis Reese

Address..... Westminster, Md.

19. (Date recd by registrar)..... 12/18/45
19. (Date of death)..... 12/17/45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Carroll

City or town..... rural Patapsco

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 17 1945 at 3 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 - 1945 to Dec 17 1945 and that I last saw her alive on Dec 16 1945.

Immediate cause of death.....

Common infection
" liveDuo to..... Myocarditis (ch)
Neoplasm (ch)

Duo to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

My

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

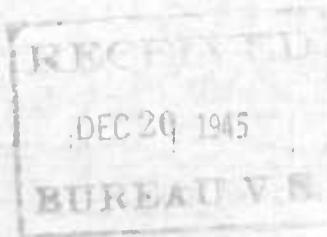
Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

W. C. Jamette M.D.
Westminster, Md. 12-12-45
M. D. or other
Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 840

12152

CERTIFICATE OF DEATH

Reg. Dlat. No. 80

1. PLACE OF DEATH:

County

City or town

Carroll

New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or Race

6. (a) Single, married, widowed, or divorced

male white single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

1945

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town New Windsor

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 1945 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1945 to December 25 1945

and that I last saw him alive on December 23 1945

Immediate cause of death

Inanition

Due to Refusal to eat - mentally defective

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

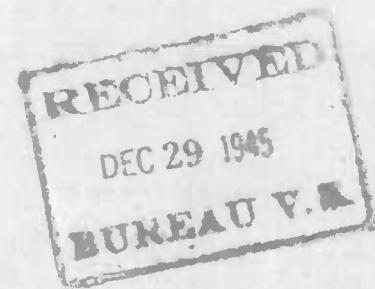
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Date signed 12-26-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

12153

76

Reg. Dist. No.

1. PLACE OF DEATH:

County CarrollCity or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Flora Virginia Warchine

3. (b) Social Security Number

None4. Sex F5. Color or race W6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 19 18208. (c) If alive, give age 100 years8. AGE: Years 69 Months 7 Days 21 If less than one dayhrs. min. 9. Birthplace Melrose Md.
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Eli Warchine13. Birthplace Md.14. Maiden name Annmary Grigling15. Birthplace Md.16. Informant Mrs. Norman E. ArkwrightAddress 73 Bond St. Westminster, Md.17. Burial Burial Date thereof Dec. 13 - 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Silverside CemeteryLocation Silverside Md.18. Funeral director N.B. Banks & SonAddress Westminster Md.19. 12/10/46 46 Delwood

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County CarrollCity or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 73 Bond

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10th 1945 at 5 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1 - 44 Dec. 10, 1945and that I last saw her alive on Dec 8th 1945Immediate cause of death CancerRight Breast.

DURATION

2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

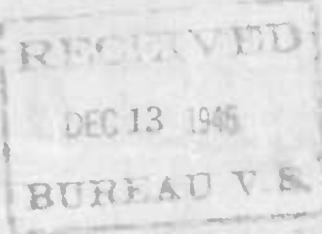
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John R. Foyt, M.D. D. or otherAddress Westminster Md. Date signed 12/10/45



PLEASE WRITE PLAINLY, WITH UNADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

12154

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 3 days

3. (a) FULL NAME

Melvin Watring

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	married

6. (b) Name of husband or wife Genevieve Watring

7. Birth date of deceased (mo., day, yr.) unknown May 25, 1910

8. AGE: Years Months Days It less than one day
35 6 25 hrs. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business

FATHER 12. Name Unknown Raymond Watring

13. Birthplace Aurora, W. Va.

MOTHER 14. Maiden name Unknown Ella Huff

15. Birthplace Preston, W. Va.

16. Informant Records of Springfield State Hospital, Sykesville, Md.

17. Burial Date thereof Dec. 24, 1945
(Burial, cremation, or removal. Which?)

Cemetery or crematory Aurora

Location Aurora, W. Va.

18. Funeral director J. D. A. Duncan

Address Thomas, W. Va.

19. Date rec'd by registrar 1945 C. Harry Zeller
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State West Virginia County

City or town Kempton
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20, 1945, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 17, 1945, to December 20, 1945, and that I last saw him alive on December 20, 1945.

Immediate cause of death

Syphilis, Aortitis

Due to

Due to

Other conditions Psychotic & syphilitic condition unknown
During pregnancy unknown
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

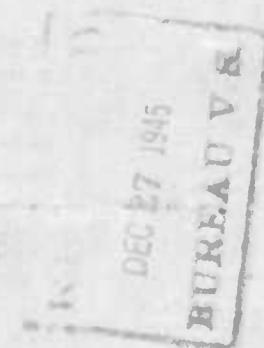
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arnold H. Siebert M.D.

M. D. or other

Address 111 Hosp., Sykesville, Md. Date signed 12-22-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17

CERTIFICATE OF DEATH

Reg. Dist. No. 76

12155

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7.1 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 115 Liberty St. (If rural, give location)
2.(a) If veteran, name war Spanish American

3. (a) FULL NAME

Capt. John Nicholas Weigle

3. (b) Social Security Number

300

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife Raffina Smith
7. Birth date of deceased (mo., day, yr.) March 16 1870
8. (c) If alive, give age 72 years

8. AGE: Years 75 Months 9 Days 14 If less than one day
hrs. _____ min. _____

9. Birthplace Gettysburg, Pa.
(Town, county, and state)

10. Usual occupation 6 A.R. R.R. Clerk of Office - 5th Commissioner

11. Industry or business

MOTHER FATHER
12. Name John Nicholas Weigle

13. Birthplace Gettysburg, Pa.

14. Maiden name Lucinda Snyder

15. Birthplace Gettysburg, Pa.

16. Informant Edgar Weigle

Address 16 E Main Westminster, Md.

17. Burial Burial Date thereof Jan 9 - 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Madison Branch Cemetery

Location Westminster, Md.

18. Funeral director A. B. Bankhead & Sons

Address Westminster, Md.

19. 1/1 46 of December Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 - 1945 1945, a.m. 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1932 1945, to Dec 30 - 1945 and that I last saw him alive on Dec 29 - 1945

Immediate cause of death

Myocarditis (chr)
Septicemia (chr)

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations None Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. None Date of _____

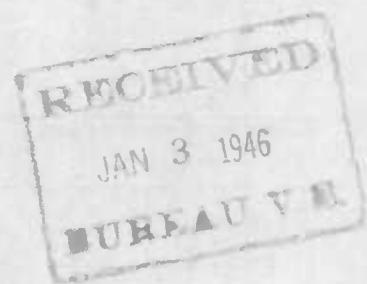
Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury _____ Injured at work? _____

23. SIGNATURE W. C. Germelton M. D. or other

Address Washington, D.C. Date signed 12-31-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH:

County... Carroll

City or town... Tyrone

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Ida Theresa Weishaar

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

F W widow

6.(b) Name of husband or wife George F. Weishaar

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1858 8.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
87 2 (3) 2

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name Frederick Englar

13. Birthplace Germany

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mrs. Carroll Weishaar

Address Westminster, Md. R.D.

17. Burial Date thereof Dec. 29, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baust

Location Near Tyrone, Md.

18. Funeral director C. O. FUSS & SON

Address Taneytown, Md.

19. Dec. 29, 1945
(Date rec'd by registrar)Margaret R. Englar
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27, 1945, at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 26, 1945, to Dec. 27, 1945, and that I last saw her alive on Dec. 26, 1945.

Immediate cause of death

Artificial respiration

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

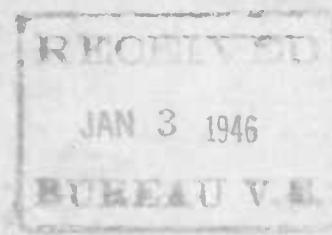
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John D. Stewart, M.D. or other
Westminster, Md. Date signed Dec. 29, 1945



(MRC)

MOITAROU

MOITAROU

78

(83)

79

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

CERTIFICATE OF DEATH

Reg. Dist. No. 12157

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 yrs 2 mos 18 days

Hospital, institution, or street address where death occurred: Maryland State Hospital

How long in hospital or institution? 28 yrs 2 mos 18 days

3. (a) FULL NAME

4. Sex M

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife: David C Whipple

7. Birth date of deceased (mo., day, yr.) Oct 15th 1876

8. (c) If alive, give age years

8. AGE: Years 69 Months 2 Days 5 If less than one day hrs. min.

9. Birthplace: Md.

(Town, county, and state)

10. Usual occupation: Foreman

11. Industry or business: Lope

12. Name: Benjamin J. Kerr

13. Birthplace: Md.

14. Maiden name: Helen M. Kerr

15. Birthplace: Md.

16. Informant: Clarence Whipple

Address: 742 W Washington St

17. Burial, cremation, or removal. Which? Burial

Date thereof: Oct. 22, 1945

(month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Md.

18. Funeral director: C. W. Coffman

Address: Hagerstown, Md.

19. Date rec'd by registrar: Dec. 20, 1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md.

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2. (a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 20, 1945, at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Oct 22, 1945, to Dec 20, 1945,

and that I last saw him alive on Dec 20, 1945.

Immediate cause of death:

Chronic Bronchitis

Due to:

Card. Arterit. Sclerosis

Due to:

Hypertension

Other conditions:

(Include pregnancy within 3 months of death)

Major findings or operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE: H. J. Hostin, M.D.

M. D. or other

Address: Sykesville, Md.

Date signed: Dec 20, 1945

RECEIVED

DEC 26 1945

BUREAU V



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12158

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County Carroll

City or town Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 21 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 1 month, 21 days

3. (a) FULL NAME

Mary White

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) August 27, 1906
6. (c) If alive, give age years

8. AGE: Years 39 Months 3 Days 24 If less than one day
hrs. min.

9. Birthplace Huntington, Long Island
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name Not known John M. White

13. Birthplace Not known Brooklyn, N.Y.

14. Maiden name Not known Susan Pearson

15. Birthplace Not known Brooklyn, N.Y.

16. Informant Records of Springfield State Hospital, Sykesville, Md.

Burial Burial Date thereof Dec. 26, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenwood Cemetery
Location New York

18. Funeral director C. Harry Zeller

Address Sykesville, Md.

19. Date rec'd by registrar Dec. 22 1945 C. Harry Zeller
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester
City or town Stockton

(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 19. 45 at 7:50 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 31 19. 45 to Dec. 21 19. 45 and that I last saw her alive on December 21 19. 45

Immediate cause of death.....

Pulmonary Tuberculosis DURATION 13 years

Due to.....

Due to.....

Other conditions.....

Minor Depressive Psychosis (Indicate pregnancy within months of death) 2 years

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Arnold H. Eichert M.D. M. D. or otherAddress 1st Hosp., Sykesville, Md. Date signed 22-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 460

12159

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH:

County

City or town

Carroll

Greenmount

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

50 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William A. White

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m

w

Married

6. (b) Name of husband or wife

Cora M. Cullison

6. (c) If alive, give age

53

years

7. Birth date of deceased (mo., day, yr.)

March 12 1888

8. AGE:

Years	Months	Days	11 less than one day
57	9	4	hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Brick-Layer

11. Industry or business

William A. White

FATHER

12. Name

Maryland

13. Birthplace

Annie Porter

14. Maiden name

Maryland

15. Birthplace

Maryland

16. Informant

Mrs. M. A. White

Address

Greenmount Md

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof 12-20-45

(month) (day) (year)

Cemetery or crematory

Greenmount

Location

Carroll Co Md

18. Funeral director

Edwin Tipton

Address

Hampstead Md

19. Dec. 19

19 45

John S. Hughes Jr.

Date rec'd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Carroll

City or town

Greenmount

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 16 1945 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated. That I attended deceased from

July 1945 to Dec. 16 1945

and that I last saw him alive on Dec. 15 1945

Immediate cause of death

Carcinoma of Stomach 1 year

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Carcinoma of Stomach Date of op. Aug. 1945

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

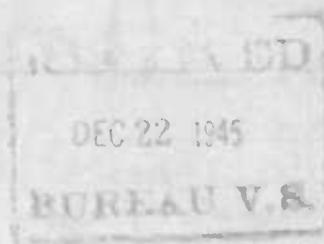
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. C. Partin, Jr. M. D. or other

Address Date signed Dec. 18 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

12160

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH: Carroll
 County
 City or town rural near Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 33 yr., 10 mo., 8 days
 Hospital, institution, or street address where death occurred: Springfield State Hospital
 How long in hospital or institution? 33 yr., 10 mo., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County
 City or town Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1148 W. Fayette Street
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME
 John W. Wilson
 3. (b) Social Security Number
 none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	unknown

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
66	?	?	hrs. min.

9. Birthplace..... York -

(Town, county, and state)

10. Usual occupation..... electrician

11. Industry or business.....

FATHER
 12. Name..... York
 13. Birthplace.....

MOTHER
 14. Maiden name..... York
 15. Birthplace.....

16. Informant..... Springfield State Hosp. records
 Address Sykesville, Maryland

17. Burial..... Date thereof Dec. 18, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Springfield State Hosp. Com.

Location..... Sykesville, Md.

18. Funeral director..... C. Harry Wilson

Address..... Sykesville, Md.

19. Date rec'd by registrar..... Dec. 18, 1945
 (Date rec'd by registrar) C. Harry Wilson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 16 1945, at 4:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 May 1, 1943, to December 16, 1945,
 and that I last saw him alive on December 16, 1945.

Immediate cause of death..... Coronary occlusion
 DURATION..... instant

Due to.....

Due to.....

Other conditions..... Dementia precox
 DURATION..... 40 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE..... Robert Bertrand May, M.D.
 Springfield State Hospital M. D. or other

Address..... Sykesville, Maryland Date signed 12-16-45

RECEIVED

DEC 20 1945

FEDERAL BUREAU OF INVESTIGATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1063

12161

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:

Carroll County

City or town: Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Susanna H Wilson

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife: William H Wilson

7. Birth date of deceased (mo., day, yr.) February 6 - 1854

8. AGE: Years Months Days If less than one day
91 10 10 hrs. min.9. Birthplace: Carroll Co Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

12. Name: Hattieville

13. Birthplace: Maryland

14. Maiden name: Not Known

15. Birthplace: Not Known

16. Informant: Mrs. Charles Selby

Address: Union Bridge

17. Burial Date thereof: Dec. 15 - 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Church of God Cemetery

Location: Glencoe Maryland

18. Funeral director: D. D. Hartley & Sons

Address: Union Bridge & New Market Rd

19. Date rec'd by registrar: Dec. 18 1945

Signature: F. A. Chapman
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland

County: Carroll

City or town: Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 16

1945

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Dec. 14 1945 to Dec. 16 1945

and that I last saw her alive on Dec. 15 1945

Immediate cause of death: Cerebral Hemorrhage

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury:

Injured at work?

23. SIGNATURE: J. H. Weyman M.D.

M. D. or other

Address: 17th and Market Streets

Date signed: Dec. 17

RECEIVED

JAN 17 1946

BUREAU F.B.I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of MARYLAND STATE DEPARTMENT OF HEALTH
year of birth shown on film G99 2411 N. Charles St., Baltimore 53
12/26/45 dm

CERTIFICATE OF DEATH

12162
74
Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

Carroll

Joperville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 9 mos 22 da

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 26 yrs 9 mos 22 days

3. (a) FULL NAME

Mary J. Wode

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Dec 25 - 1877-1880

8. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day

68

0

10

hrs.

min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

Housework

11. Industry or business

Charles Wode

12. Name.....

Charles Wode

13. Birthplace

Baltimore

14. Maiden name.....

Alice Elcock

15. Birthplace

Baltimore

16. Informant.....

Charles Wode

Address

4019 Edmondson Ave Baltimore

17. Burial

(Burial, cremation, or removal; which?)

Date thereof

Oct 7-45

(month) (day) (year)

Cemetery or crematory

Dredge Bridge Cemetery

Location

Kearney Md

18. Funeral director

W. W. W. Book Inc

Address

1217 Q St N.W.

19. Date rec'd by registrar

Dec 6 1945

(Date rec'd by registrar)

C. Harry Wode

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

Street No. 4019

County Baltimore

(If rural, give LOCATION)

(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5 th 1945 at 8:45

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 19th 1945 to Dec 5th 1945

and that I last saw her alive on Dec 5th 1945

Immediate cause of death.....

Carcinoma of face

DURATION

Due to.....

Epilepsy

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

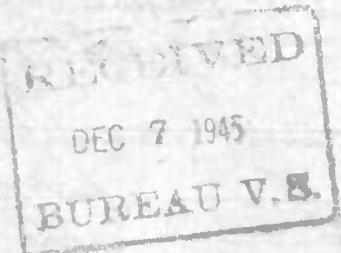
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE J. J. Gastin M. W. or other

Address Joperville Md Date signed 12/5/45



M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 463

CERTIFICATE OF DEATH

12163

Reg. Dist. No. 78

1. PLACE OF DEATH:

County.....

Carroll

City or town.....

Westminster Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Mary Lizzie John

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife.....

William John Jr

7. Birth date of

deceased (mo., day, yr.)

January 1 1862

8. AGE:

Years

Months

Days

If less than one day

83

61

2

hrs.

min.

9. Birthplace.....

Frederick County Maryland

(Town, county, and state)

10. Usual occupation.....

School Teacher - Horsemanship

11. Industry or business

12. Name.....

Rosalie Hoffman

13. Birthplace

Maryland

14. Maiden name.....

Linda A Snook

15. Birthplace

Maryland

16. Informant.....

William John Jr

Address

Westminster Rd Route 6

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Dec 5 1945

(month) (day) (year)

Cemetery or crematory.....

Dixie Beach Cemetery

Location.....

Westminster Road

18. Funeral director.....

D D Hartle & Sons

Address

Union Bridge & New Windsor Rd

19. (2) - 6 - 1945

(Date rec'd by registrar)

Ernest Bucker

S M Farva & R

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Carroll

City or town.....

Westminster Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Dennings Road

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

December 3 1945 11:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/2 1945 to 12/3 1945

and that I last saw her alive on 12/3 1945

Immediate cause of death.....

Hemorrhage; dehydration

DURATION

Due to.....

Obstruction of

bowel (3)

,

Due to.....

Carcinoma of rectum (3)

,

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? (City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE.....

E L Seigman M. D. 12/3/45

Address.....

Union Bridge

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

CERTIFICATE OF DEATH

Reg. Dist. No. 76

12164

1. PLACE OF DEATH:
Carroll
County..... Westminster
City or town..... (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... life
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

3. (a) FULL NAME
Clara F. Zahn

4. Sex female	5. Color or race white	6. (a) Single, married, widowed, or divorced single
------------------	---------------------------	--

8. (b) Name of husband or wife.....

7. Birth date of
deceased (mo., day, yr.)
..... 1867

8. AGE: Years
about 78 Months Days If less than one day
..... hrs. min.

9. Birthplace..... Carroll County, Maryland
(Town, county, and state)

10. Usual occupation..... House work

11. Industry or business

FATHER
12. Name..... Jacob T. Zahn

MOTHER
13. Birthplace..... Maryland

14. Maiden name..... Not known

15. Birthplace..... Germany

16. Informant..... Roy L. Zahn

Address..... Frizzellburg, Md.

17. burial
(Burial, cremation, or removal. Which?)
..... Cemetery or crematory..... Krider's Cemetery

Location..... Westminster, Md.

18. Funeral director..... J. Francis Reese

Address..... Westminster, Md.

19. (Date rec'd by registrar)..... 12/23/45
.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
Maryland
County..... Carroll
City or town..... Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 203 Pennsylvania Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war.....
3. (b) Social Security Number
none

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 22, 1945, at 2 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
....., 1945, to 1945,
and that I last saw her alive on 10 Dec 22, 1945.

Immediate cause of death.....
Heart disease
with fibrillation
DURATION
2 mo.

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... J. Francis Reese
M. D. or other.....

Address..... Westminster, Md. Date signed 12/23/45

